

VR A15 (4)
15M 9/60

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 123 West Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James P BASSFORD		4. DATE OF DEATH July 10 19 61		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 21, 1899	
9. AGE (In years last birthday) 62		10. IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Taxi Cab		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME James Bassford		14. MOTHER'S MAIDEN NAME Mammie Asquith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 214 05 0733		17. INFORMANT Mrs. Lucy M. Bassford	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cerebral Hemorrhage		19. INTERVAL BETWEEN ONSET AND DEATH 8 hrs		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		21. WAS DEATH UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 6:40 P.M.		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6 Shaw St., Annapolis, Md.	
26. (City or town) Annapolis		27. (County) Anne Arundel		28. (State) Md.	
29. I certify that (I) (the undersigned) attended the deceased from July 10, 1961 to July 10, 1961 , that (I) (the undersigned) saw the deceased alive on July 10, 1961 , and that death occurred at 6:40 P.M. from the causes and on the date stated above.		30. SIGNATURE James R. Martin		31. DATE SIGNED 7-11-61	
32. PHYSICIAN'S NAME (Type) James R. Martin		33. ADDRESS 6 Shaw St., Annapolis, Md.		34. REC'D BY REGISTRAR Arthur S. Hines	
35. BURIAL, CREMATION, REMOVAL (Specify) Burial		36. DATE THEREOF July 13, 61		37. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial	
38. LOCATION (City, town or county) Annapolis, Md.		39. (State) Md.		40. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home	
41. ADDRESS Annapolis, Md.		42. DATE JUL 13 '61		43. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

M

05450

10-25

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XEROX CORPORATION

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

7471

CERTIFICATE OF DEATH

Reg. Dist. No.

07461

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>Washington, DC</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shady Side, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, DC</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>61 S. St., N.W.</i>	
3. NAME OF DECEASED (Type or print) <i>Phillip E. Bembrey</i>		4. DATE OF DEATH <i>July 2 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/2/08</i>
9. AGE (In years last birthday) <i>53</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. S. Gov't.</i>	11. BIRTHPLACE (State or foreign country) <i>Hertford, N.C.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Edward Bembrey</i>	
14. MOTHER'S MAIDEN NAME <i>Claudia Guyther</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT <i>Marie L. Bembrey</i> Address <i>Same as #2 above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive cardiovascular disease</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19 and that death occurred at 9:30 PM, from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Willard F. Smith</i> M.D.		ADDRESS (Street, city or town, state) <i>Shady Side, Md.</i> DATE SIGNED <i>7/2/61</i>	
PHYSICIAN'S NAME (Type) <i>WILLARD F. SMITH</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>7/6/61</i>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <i>Hertford, No. Car.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert J. McInnis</i> ADDRESS <i>1820 9th St., N.W.</i>		24a. REC'D BY REGISTRAR <i>JUL 7 '61</i> DATE	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
7472					07462								
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE Maryland b. COUNTY Wicomico								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 2 ye., 11 mo 15 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury			d. STREET ADDRESS Lake & Collins Str.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give place of death) Crownsville State Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last George Henry Bloodsworth					4. DATE OF DEATH Month Day Year 7 15 19 61								
5. SEX Male		6. COLOR OR RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1901 Feb 2		9. AGE (In years last birthday) 60 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Timber		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
13. FATHER'S NAME Dennis Bloodsworth					14. MOTHER'S MAIDEN NAME Molly Nutter								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown					16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital Records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Arteriosclerosis (a), stating the underlying cause last. } DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Salisbury		(County) Wicomico					
21. I certify that (I) (this hospital) attended the deceased from 7/31 1961 to 7/15 1961 that (I) (we) last saw the deceased alive on 7/15 1961, and that death occurred at 4:50 a.m. the causes and on the date stated above.													
22a. SIGNATURE L. Benedict M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) L. BENEDICT M.D.					22d. ADDRESS Crownsville State Hospital								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7 20 61		23c. NAME OF CEMETERY OR CREMATORY St. Paul Cem.		23d. LOCATION (City, town or county) (State) Mt. Vernon, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley					ADDRESS Salisbury, Md		25a. REC'D BY REGISTRAR DATE JUL 25 '61		25b. REGISTRAR'S SIGNATURE C. L. H. H. H.				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07464

1. PLACE OF DEATH a. COUNTY A.A. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY A.A. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERNA PARK		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BENFIELD RD.		d. STREET ADDRESS BENFIELD RD.	
3. NAME OF DECEASED (Type or print) First LOUIS Middle OLIVER Last BRENNAN		4. DATE OF DEATH Month JULY Day 3 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 14 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY SELF	11. BIRTHPLACE (State or foreign country) MD
13. FATHER'S NAME EDW. M. BRENNAN		14. MOTHER'S MAIDEN NAME NANNIE DECOURCY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address NANNIE BRENNAN (SISTER) ABOVE		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lobar, bilateral 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Parkinsonism DUE TO (c) Generalized Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 1953 to July 3, 1961 , that (I) (we) last saw the deceased alive on July 2, 1961 , and that death occurred on July 3, 1961 at 11:30 AM from the causes and on the date stated above.	
22a. SIGNATURE Francis I. Codd		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Francis I. Codd M.D.		22d. ADDRESS Severna Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-6-61	23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM
23d. LOCATION (City, town, or county) (State) BALTO. MD		25a. REC'D BY REGISTRAR Robert S. Barranco - SEVERNA PK, MD	
25b. REGISTRAR'S SIGNATURE Robert S. Barranco		25c. DATE JUL 6 '61	

7475 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07465

1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. LENGTH OF STAY IN 1b <i>45 hrs. 8 MON - 12 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Crownsville State Hosp.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> <i>3V01-4</i>	
3. NAME OF DECEASED (Type or print) First <i>Mabel</i> Middle <i>Burke</i> Last <i>Burke</i>		4. DATE OF DEATH Month <i>7</i> Day <i>11</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-20-1890</i>
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>11</i>	IF UNDER 24 HRS. Hours <i>11</i> Min. <i>1961</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>unknown</i>	
17. INFORMANT <i>Hospital Records.</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Embolism of Pulmonary artery</i> DUE TO (b) <i>Thrombosis of femoral vein</i> DUE TO (c) <i>Fracture of Right Femur</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>—</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>—</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Patient slipped and fell in bath room</i>	
20c. TIME OF INJURY Month, Day, Year <i>6-26-61</i> Hour <i>6 a.m.</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Crownsville Hosp.</i>	20f. (City or town) <i>ARCO</i> (County) <i>MD</i> (State) <i>MD</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>7-11-61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>	22b. DATE THEREOF <i>7-13-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. PK</i>	22d. LOCATION (City, town, or county) <i>Arbutus</i> (State) <i>MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sullivan Funeral Home</i>		24a. REC'D BY REGISTRAR <i>JUL 17 61</i>	
ADDRESS <i>104-13 N. Arlington Ave.</i>		24b. REGISTRAR'S SIGNATURE <i>Edward S. Plank</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

100-1000

NEW YORK
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WILLIAM

may be retained by the hospital or attending physician. TO FILE: The death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07466

7475

1. PLACE OF DEATH a. COUNTY <u>A. A</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape St Clair</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>R. F. D. Annapolis</u>		e. STREET ADDRESS <u>R. F. D. Annapolis Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Agnes</u> Last <u>BUSCH</u>		4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 16-1872</u>
9. AGE (In years last birthday) <u>88</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>George R. Holt</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>R. Linwood Busch</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden cardiac failure</u> DUE TO <u>410X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Mitral insufficiency with chronic cardiac failure</u> DUE TO (c) <u>Senility and malnutrition</u>			INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>20 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>July</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 13</u> , 19 <u>61</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bertrand C. R. Gall</u>		DATE SIGNED <u>Aug 5-1961</u>	
PHYSICIAN'S NAME (Type) <u>Bertrand C. R. Gall</u>		ADDRESS (Street, city or town, state) <u>Cape St Clair, Rt 4, Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG 2-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR & SONS</u>		24a. REGISTERED BY REGISTRAR <u>Aug 2 1961</u>	
ADDRESS <u>ANNAPOLIS MD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07467

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN b 2 yrs. 1 mo. 29 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Beechville d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) Albert First Middle Last		4. DATE OF DEATH 7 10 1961 Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Alford Butler		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) 491X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic Brain Syndrome Associated with Central Nervous System Syphilis		17. INFORMANT Address Hospital Records	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 5/11, 1959, to 7/10, 1961, that (I) (we) last saw the deceased alive on 7/10, 1961, and that death occurred at 12:15 M. from the causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 7/10/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-15-61	
23c. NAME OF CEMETERY OR CREMATORY St. Peter's		23d. LOCATION (City, town or county) (State) Bridge Md	
24. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		25a. REC'D BY REGISTRAR JUL 18 61	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

7473

CERTIFICATE OF DEATH

Reg. Dist. No. 07468

1. PLACE OF DEATH a. COUNTY ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY PA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 N.E. Furnace Branch Road		d. STREET ADDRESS 106 N.E. Furnace Branch Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GERALDINE S. CARR		4. DATE OF DEATH Month JULY Day 8 Year 1961	
5. SEX Fe	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1923
9. AGE (In years lost birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Hoopers Cotton Mills	
11. BIRTHPLACE (State or foreign country) Altoona, Pa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred Gates		14. MOTHER'S MAIDEN NAME Ester McCune	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 384-18-9853	
INFORMANT Roby B. Carr, Sr., 106 N.E. Furnace Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Cervix DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 60 to July 8 , 19 61 , that I last saw the deceased alive on July 8 , 19 61 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmond I. Moushabek M.D.		ADDRESS (Street, city or town, state) 2101 S. Ritchie Highway DATE SIGNED 7/8/61	
PHYSICIAN'S NAME (Type) EDMOND I. MOUSHABEK		Glen Burnie, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-11-61	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE JUL 11 '61	
		24b. REGISTRAR'S SIGNATURE William S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7479
07469
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>9 years 4 mos. 24 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>706 S. Sharp Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u></u> Last <u>Carter</u>		4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>19 61</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 15, 1886</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stevedore</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE County & State or foreign country <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Riley Carter</u>		14. MOTHER'S MAIDEN NAME <u>Rose ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychosis with Cerebral Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>-----</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/26</u> , 19 <u>52</u> , to <u>7/20</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/20</u> , 19 <u>61</u> , and that death occurred at <u>3:30</u> a.m., from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED <u>7/20/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>26 July 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Union of Md. Hosp.</u>		23d. LOCATION (City, town or county) (State) <u>Balt. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese II</u>		25a. REC'D BY REGISTRAR <u>JUL 28 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>		25c. ADDRESS <u>108 W. Washington St.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7480

07470

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bead on arrival</u> <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Weems Creek</u>	
3. NAME OF DECEASED (Type or print) <u>Walter N COLLISON</u>		4. DATE OF DEATH <u>July 10 19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1885</u>
9. AGE (In years, last birthday) <u>76</u> yrs.		10. AGE (In years, last birthday) <u>76</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William James Collison</u>		14. MOTHER'S MAIDEN NAME <u>Eugenia Purdy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>R13 32 8771</u>	
17. INFORMANT <u>Mrs Ethel Collison</u>		Address <u>Wife same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>arteriosclerotic CVD</u> DUE TO (c) <u>27 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>27 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>3:40</u> p.m. <u>P.M.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>1:35 P.M.</u> 19 <u>61</u> to <u>7:10 P.M.</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/24</u> 19 <u>61</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Shipley</u>		22b. DATE SIGNED <u>July 13 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK M. SHIPLEY</u>		22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 13, 61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Jul 13 '61</u>	
ADDRESS <u>Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7491
CERTIFICATE OF DEATH

07471

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Nursing Home</u>		d. STREET ADDRESS <u>1 23 Murray Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph E. Cromwell</u>		4. DATE OF DEATH <u>July 20 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1886</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Admin. Assistant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alexander Cromwell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sullivan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Helen W. Cromwell</u>	
17. INFORMANT <u>Helen W. Cromwell</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (b) <u>0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (c) <u>0</u> DUE TO (d) <u>0</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1936</u> to <u>20 July 1961</u> . that (I) (we) last saw the deceased alive on <u>20 JULY 1961</u> and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		22d. ADDRESS <u>73 Franklin St Annapolis Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-22-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor-Sons</u>		25a. REC'D BY REGISTRAR <u>June 26 '61</u>	
ADDRESS <u>Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>William L. House</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7482 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07472**

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARCO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>52 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GENERAL</u>		d. STREET ADDRESS <u>1 Rt. 1 - Box 229</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William T. CROUSE</u>		4. DATE OF DEATH Month Day Year <u>7 25 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2-1877</u>
9. AGE (In years last birthday) <u>84 yrs.</u>		10. UNDER 1 YEAR Months Days Hours Min. <u>84 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(ret'd) Warden</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A.Co., Jail</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>James H. Crouse</u>		14. MOTHER'S M maiden NAME <u>Anniem. Crouse</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Miss Ida Crouse, Box 229, Route 1, Severn, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Trachea tip tight</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 wks.</u> <u>YRS.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Free Wheel of same</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6.3</u> p.m. <u>161</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Arden MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		DATE SIGNED <u>7/25/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-28-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial Cemetery, Millersville, Maryland</u>		22d. LOCATION (City, town, or county) (State) <u>Arden MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore</u>		24a. REC'D BY REGISTRAR DATE <u>8/1 28 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7483

CERTIFICATE OF DEATH

07473

Items 10a, 13 & 14 Film G292 8/2/61

1. PLACE OF DEATH
a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY in lb

3 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Anne Arundel General Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Katherine

CROWNER

5. SEX

Female

6. COLOR OR RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

April 5, 1888

4. DATE OF DEATH

Month

Day

Year

July

24

1961

9. AGE (in years last birthday) 73 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Richard Scott

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

16. SOCIAL SECURITY NO. 17. INFORMANT

Address

18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

Cerebral hemorrhage due to hypertension

DUE TO

Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Right hemiplegia

INTERVAL BETWEEN ONSET AND DEATH

3 days

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (the doctor) attended the deceased from July 21, 1961 to July 24, 1961, that (I) last saw the deceased alive on July 24, 1961, and that death occurred at 7:30 A.M. from the causes and on the date stated above.

22. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

James R. Martin

ATTENDING PHYS. ☒

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

7/24/61

22d. ADDRESS

6 Shaw St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

7/26/61

23c. NAME OF CEMETERY OR CREMATORY

Matthew

23d. LOCATION (City, town or county)

Shady Side Rd

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Arthur C. Hardisty

ADDRESS

25. REC'D BY REGISTRAR

DATE JUL 28 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
ma retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Page 4 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7484

CERTIFICATE OF DEATH

07474

Item 9 Film 0292 8/4/61 JWK

1. PLACE OF DEATH a. COUNTY <u>A.D.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>RA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forest Glen Dr.</u>		d. STREET ADDRESS <u>FOREST Glen DR.</u>	
3. NAME OF DECEASED (Type or print) First <u>LIZABETH</u> Middle <u>MARIE</u> Last <u>CUPPLEMAN</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10, 1889</u>
9. AGE (In years last birthday) <u>72 1/2</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11c. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Peterson</u>		14. MOTHER'S MAIDEN NAME <u> </u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac decompensation</u> DUE TO <u>Rheumatic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 2, 1949</u> to <u>July 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 22, 1961</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R.M. McLaughlin</u> M.D.		22b. DATE SIGNED <u>7/22/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>		22d. ADDRESS <u>3708 Mountain Rd. Pasadena, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>7-26-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto</u> <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>McColly Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 24 '61</u>	
ADDRESS <u>130 E. Fort Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hanna</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7486 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07476

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary. If the death is a funeral director, Pages 1, 2, and 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 4 and 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before death) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN lb				d. STREET ADDRESS 2633 E. Chase Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woods, 1/2 mile off Marley Neck Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LONNIE Middle Last				4. DATE OF DEATH Month July Day 25 Year 1961			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-19-1904	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bulldozer operator - Construction		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 57 yrs.		11. BIRTHPLACE (State or foreign country) Whitestone, Va.	
13. FATHER'S NAME Lonnie Decatur		14. MOTHER'S MAIDEN NAME Mary Rice		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. 817-05-4136		17. INFORMANT Mrs. Julia Decatur		Address 2633 E. Chase St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Crushed chest, rupture of heart, massive hemorrhage in left chest cavity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Knocked off bulldozer by tree					
20c. TIME OF INJURY Hour 1:45 p.m. Month, Day, Year 7/25 19 61		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods		20f. (City or town) (County) (State) Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Howard B. Shaub EXAMINER'S NAME (Type) Howard B. Shaub, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/26/61			
22b. DATE THEREOF 7-29-61		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or country) (State) Anne Arundel Co., Md.			
23. FUNERAL DIRECTOR Randolph L. Lelick		ADDRESS 1412 E. Preston St.		24a. REC'D BY REGISTRAR JUL 27 '61		24b. REGISTRAR'S SIGNATURE William S. Ruma	



FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be noted in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
07477											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>						c. LENGTH OF STAY IN 1b <u>1 hr.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>						d. STREET ADDRESS <u>Robinson Landing Road</u>					
3. NAME OF DECEASED (Type or print) <u>BABY</u>						4. DATE OF DEATH <u>July 23, 1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-23-1961</u>		9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR <u>23</u> Days <u>1</u> Hours <u>7</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (State or foreign country) <u>Ind</u>			
12. CITIZEN OF WHAT COUNTRY <u>USA</u>				13. FATHER'S NAME <u>? Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor F. Delker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>John A. Delker</u> Address <u>Above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Right subdural hematoma</u>											
DUE TO <u>tentorial tear</u> (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>—</u> p.m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Peter W. Rieckert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>7/24/61</u>			
EXAMINER'S NAME (Type) <u>Peter W. Rieckert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <u>Associate Pathologist</u> <input checked="" type="checkbox"/>							
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7-25-61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem</u>			
22d. LOCATION (City, town, or country) <u>Anne Arundel</u>				(State) <u>Md</u>							
23. FUNERAL DIRECTOR <u>Robert S. Banarac</u>				ADDRESS <u>Severna Park</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>			
DATE <u>Jul 27 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed by the funeral director, or by the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

Item 18-181-293

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7488 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07478

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severna Park			
c. LENGTH OF STAY IN 1b 1 hour				d. STREET ADDRESS Robinson Landing Road			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELEANOR F. DELKER				4. DATE OF DEATH Month July Day 23 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 13, 1939	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A Delker				14. MOTHER'S MAIDEN NAME Marie Christ			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT John A. Delker Address Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Overwhelming sepsis complicating full term 681X DUE TO unattended delivery							
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 9 a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Peter W. Rieckert				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Peter W. Rieckert, M.D.				M.D. ASSISTANT MEDICAL EXAMINER Associate Pathologist X			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-25-61		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem	
22d. LOCATION (City, town, or country) Glen Burnie Md				22e. (State) Md			
23. FUNERAL DIRECTOR Robert S. Baranco				24a. REC'D BY REGISTRAR Severna Park Md			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				DATE Jul 27 '61			

MEDICAL CERTIFICATION

DATE SIGNED
7/24/61



12
FOR STATE
HEALTH DEPT.

M

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1. DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, the delay should be explained in the certificate. The certificate should be executed by the Medical Director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7489 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07475

1. PLACE OF DEATH a. COUNTY A.A.Co. MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Pleasant Beach, Pasadena 30 min. c. LENGTH OF STAY in lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Stony Creek		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 3314 Strickland St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alfred C. Denson		4. DATE OF DEATH July 22, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY PRINTING	
13. FATHER'S NAME Alfred Denson		14. MOTHER'S MAIDEN NAME Margaret Schuchard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 514-01-5842	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 927.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Drowning		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Swimming	
20c. TIME OF INJURY Hour a.m. 7/22 19 61 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Stony Creek, Maryland	
20f. (City or town) A.A.		20g. (County) BALTIMORE	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. J. [Signature]		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) G. TRILMAN SCHWAB		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-26-61	
22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		22d. LOCATION (City, town, or country) (State) BALTIMORE MD.	
23. FUNERAL DIRECTOR G. TRILMAN SCHWAB		24a. REC'D BY REGISTRAR JUL 26 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline		DATE JUL 26 '61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7490

CERTIFICATE OF DEATH

07480

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>1411 Division Street Balto.17</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Henry Dent</u>		First		Middle		Last		4. DATE OF DEATH <u>July 11, 1961</u>		Month		Day		Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH <u>4-25-1882</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private homes</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Herman-D.P.W. Balto. City.</u>		Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral thrombosis due to arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive & arteriosclerotic cardiovascular disease.</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs.</u> <u>? yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoarthritis. Prostatectomy, pneumonia Univ. Hosp. June 1961.</u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Baltimore</u>		(County) <u>Anne Arundel</u>		(State) <u>Md.</u>					
21. I certify that (I) (this hospital) attended the deceased from <u>December 16, 1958</u> , to <u>July 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 8, 1961</u> , and that death occurred at <u>1:30</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>James M. Pair</u>		22b. DATE SIGNED <u>July 12, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>James M. Pair, M.D.</u>		22d. ADDRESS <u>400 N. Carrollton Avenue Balto.23,Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-15-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		23d. LOCATION (City, town or county) <u>Anne Arundel Co. Md.</u>		(State) <u>Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arington S. Phillips</u>		25a. REC'D BY REGISTRAR <u>JUL 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William L. Hanna</u>											



TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7491

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07482

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia 43			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia 43			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL				d. STREET ADDRESS 4701 Pine Street 75X-2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Earl Francis ENRIGHT				4. DATE OF DEATH Month Day Year July 17 1961			
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 Oct 1891	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer				10b. KIND OF BUSINESS OR INDUSTRY Colorado		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME EARL F. ENRIGHT				14. MOTHER'S MAIDEN NAME MARY JANE WELLS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WWII				16. SOCIAL SECURITY NO. 138-22-5498		17. INFORMANT Address LILLIAN WELLS ENRIGHT (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Myocardial Infarction DUE TO (b) Hypertension and A.S.I.A.D. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 10 minutes years (3)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) E. L. W. HARRIS				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 7-17-61							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-19-61		22c. NAME OF CEMETERY OR CREMATORY U.S.N. Academy		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor				ADDRESS San Annapolis Md		24a. REC'D BY REGISTRAR DATE JUL 20 '61	
						24b. REGISTRAR'S SIGNATURE Lillian Wells	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7492
CERTIFICATE OF DEATH
07483

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNE ARUNDEL GENERAL</u>		2. USUAL RESIDENCE (Where deceased lived, if last tuition. Residence before admission) a. STATE <u>MD.</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>RT. 2 Bayhead Road</u>	
3. NAME OF <u>Ann</u> First <u>Amelia</u> Middle <u>Estep</u> Last (Type or print)		4. DATE OF DEATH <u>7</u> Month <u>9</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/18/1894</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL M. BURD</u>		14. MOTHER'S MAIDEN NAME <u>LAURA SUPINGER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>FRANCES ESTEP</u>	
17. INFORMANT <u>FRANCES ESTEP</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Arteriosclerotic CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Diabetes Mell.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mell.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-7-1961</u> to <u>7-9-1961</u> , that (I) (we) last saw the deceased alive on <u>7-9-61</u> , and that death occurred at <u>4:55 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Stiple</u>		22b. DATE SIGNED <u>7-9-61</u>	
22c. PHYSICIAN'S NAME <u>FRANK M. STIPLEY</u>		22d. ADDRESS <u>ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/12/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck</u>		25a. REC'D BY REGISTRAR <u>11 '61</u>	
ADDRESS <u>5305 HARFORD Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND

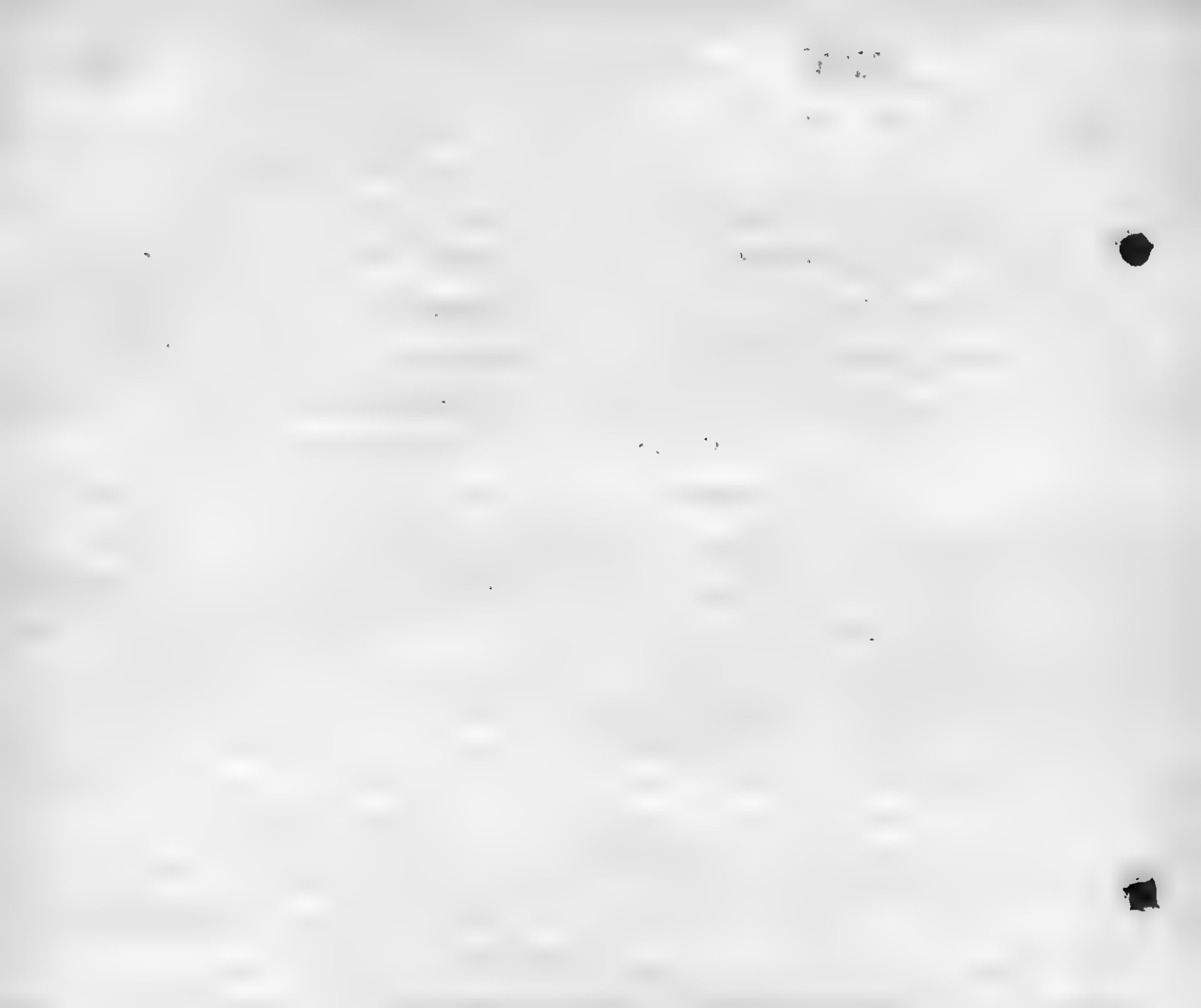
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7493

CERTIFICATE OF DEATH

07484

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STA. <u>11 mi. 60 ft.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Towson</u>		c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Towson</u>		d. STREET ADDRESS <u>413 Penna Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Birdie Fields</u>		4. DATE OF DEATH <u>July 1 1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/28/1880</u>		9. AGE (in years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u>		11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>(Unknown) - U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Amos Harvey</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth (Harvey)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Crownsville State Hospital Record</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Senility</u> (c) <u>Compression fracture L4</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Decubitus ulcers.</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years.</u> <u>12 days</u>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month. Day. Year <u>19</u> Hour a.m. <u>1</u> p.m. <u>1</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>June 26, 1961</u> , to <u>July 1st, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 1st, 1961</u> , and that death occurred at <u>3:52 PM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>George McPhillips</u>		22b. DATE SIGNED <u>6-30-61</u>		22c. PHYSICIAN'S NAME (Type) <u>George McPhillips</u>		22d. ADDRESS <u>Crownsville Md</u>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <u>Crownsville Md</u>		22g. REC'D BY REGISTRAR <u>William L. Phillips</u>		22h. REGISTRAR'S SIGNATURE <u>William L. Phillips</u>		22i. DATE <u>JUL 5 '61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Mount</u>		23d. LOCATION (City, town or county) (State) <u>Towson Baltimore Md.</u>		23e. FUNERAL DIRECTOR'S SIGNATURE <u>William L. Phillips</u>		23f. ADDRESS <u>1701 McPhillips St.</u>		23g. REC'D BY REGISTRAR <u>William L. Phillips</u>		23h. REGISTRAR'S SIGNATURE <u>William L. Phillips</u>		23i. DATE <u>JUL 5 '61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7494

CERTIFICATE OF DEATH

07485

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN b 9 mos. 3 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 927 Eutaw Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Johnnie		First		Middle		Last Ford		4. DATE OF DEATH Month 7		Day 10		Year 1961					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sep.		8. DATE OF BIRTH May 10, 1910		9. AGE (in years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 7		Days 10		IF UNDER 24 HRS. Hours 10		Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Wilmington, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Doc Ford		14. MOTHER'S MAIDEN NAME Lula ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 237-03-8384		17. INFORMANT Hospital Records		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a). 023X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Syphilitic & Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Paranoid Type with Mental Deficiency		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. TIME OF INJURY Hour a.m. ----- p.m. ----- 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20d. (City or town) -----		(County) -----		(State) -----							
21. I certify that (I) (this hospital) attended the deceased from 1/16 19 59 to 7/10 19 61 , that (I) (we) last saw the deceased alive on 7/10 19 61 , and that death occurred at 5:40 A.M. from the causes and on the date stated above.		22a. SIGNATURE L. Benedict, M. D.		22b. ADDRESS Crownsville State Hospital, Maryland		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		22d. LOCATION (City, town or county) Baltimore, Maryland		(State) -----							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-15-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION (City, town or county) Baltimore, Maryland		(State) -----									
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		24b. ADDRESS 802 Madison Ave., Balto., Md.		25a. REC'D BY REGISTRAR JUL 17 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7495
CERTIFICATE OF DEATH

67486

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY in lb 2 1/2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis
STREET ADDRESS 73 West St.

3. NAME OF DECEASED (Type or print) William First Edward Middle FORDHAM Last
4. DATE OF DEATH July Month 9 Day 19 Year 61

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH July 7 1/2 1961
9. AGE (in years; if under 1 year, last birthday) Months 2 Days 10 Hours 57 Mins. 57

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE County & State, or foreign country Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME William Thomas FORDHAM 14. MOTHER'S MAIDEN NAME Ruth Charlotte Dean

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Hospital Records Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
DUE TO Pneumonia or but
DUE TO Uterine Anoxia From but
DUE TO From but
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 July 7, 1961
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20d. (City or town) (County) (State)
20e. (City or town) (County) (State)

21. I certify that (I) (Philip Briscoe) attended the deceased from July 7, 1961 to July 9, 1961, that (I) (*) last saw the deceased alive on July 9, 1961, and that death occurred at 9:54 A.M. from the causes and on the date stated above.

22a. SIGNATURE Philip Briscoe M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 7/11/61
22c. PHYSICIAN'S NAME (Type) Philip Briscoe 22d. ADDRESS 95 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF July 11, 61 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial 23d. LOCATION (City, town or county) (State) Annapolis, Md.

24. GENERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md. 25a. REC'D BY REGISTRAR JUL 12 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hines

1
FOR STATE
HEALTH DEPT.

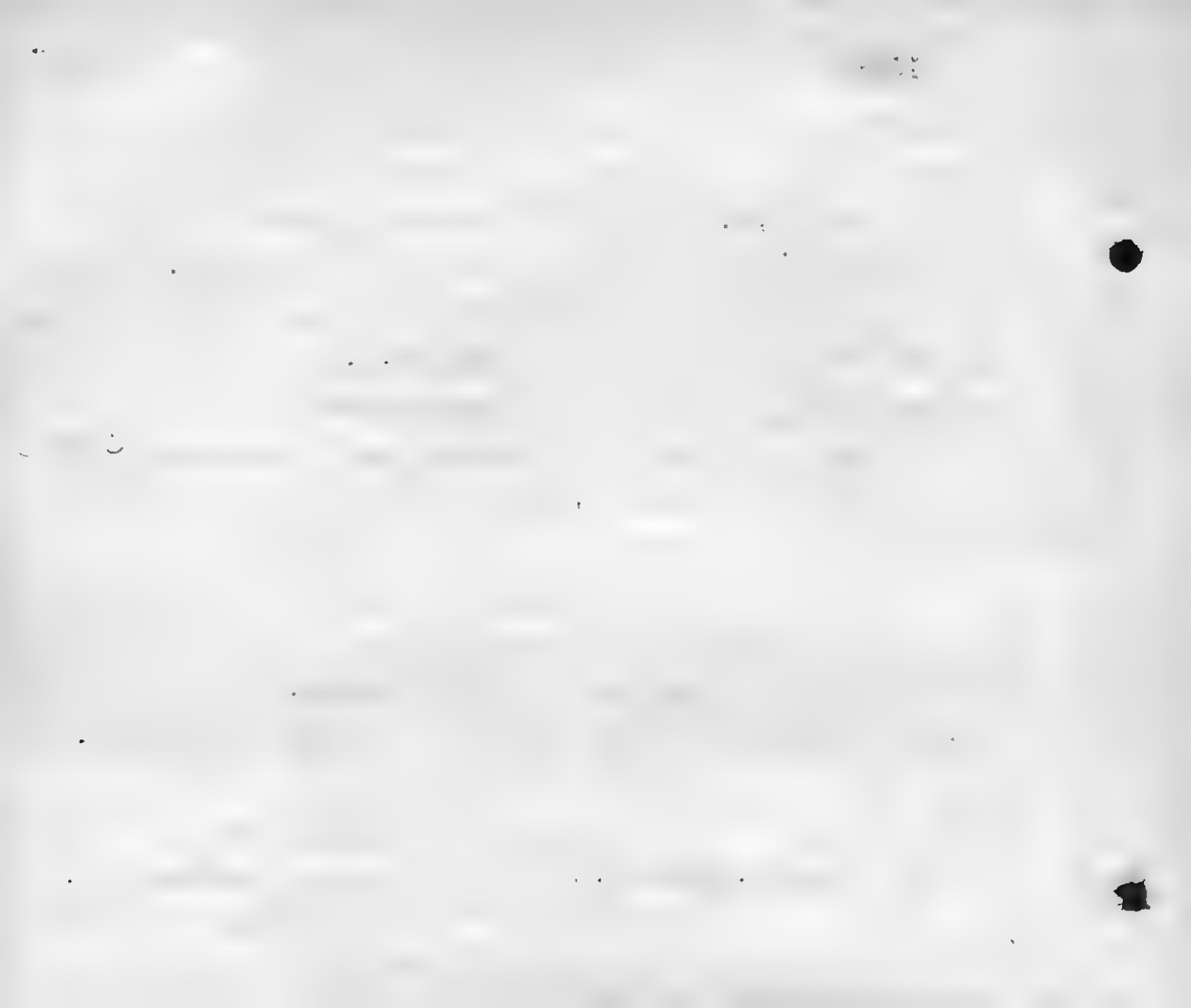
TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
7496 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07487									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potapasco Park</u>		c. LENGTH OF STAY IN 1b <u>One hour</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>	
3. NAME OF DECEASED (Type or print) <u>Lamont F. Garrett</u>		4. DATE OF DEATH <u>July 2nd.</u> 19 <u>61</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4/12/45</u>		9. AGE (In years last birthday) <u>16</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attending School</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Garrett</u>		14. MOTHER'S MAIDEN NAME <u>Rosalie Manning</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr and Mrs Ernest Garrett (parents)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>929.8</u> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <u>Went swimming with friends and drowned.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Water</u>	
20c. TIME OF INJURY Month, Day, Year <u>3.35 p.m.</u> <u>7/2</u> 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potapasco Park, A.A. Md.</u>		20f. (City or town) <u>Potapasco Park, A.A. Md.</u>		20g. (County) <u>A.A.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/2/61</u>	
ACTUAL SIGNATURE <u>Gustave H. Maubert, M.D.</u>		EXAMINER'S NAME (Type) <u>Gustave H. Maubert, M.D.</u>		Address (Street, city, town, or county) <u>Glen Burnie, Md.</u>		22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/7/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Auburn</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u>		23. FUNERAL DIRECTOR <u>Eloyo Wilson</u>		24a. REC'D BY REGISTRAR <u>5</u>		24b. REGISTRAR'S SIGNATURE <u>Christina S. H...</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO MEDICAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

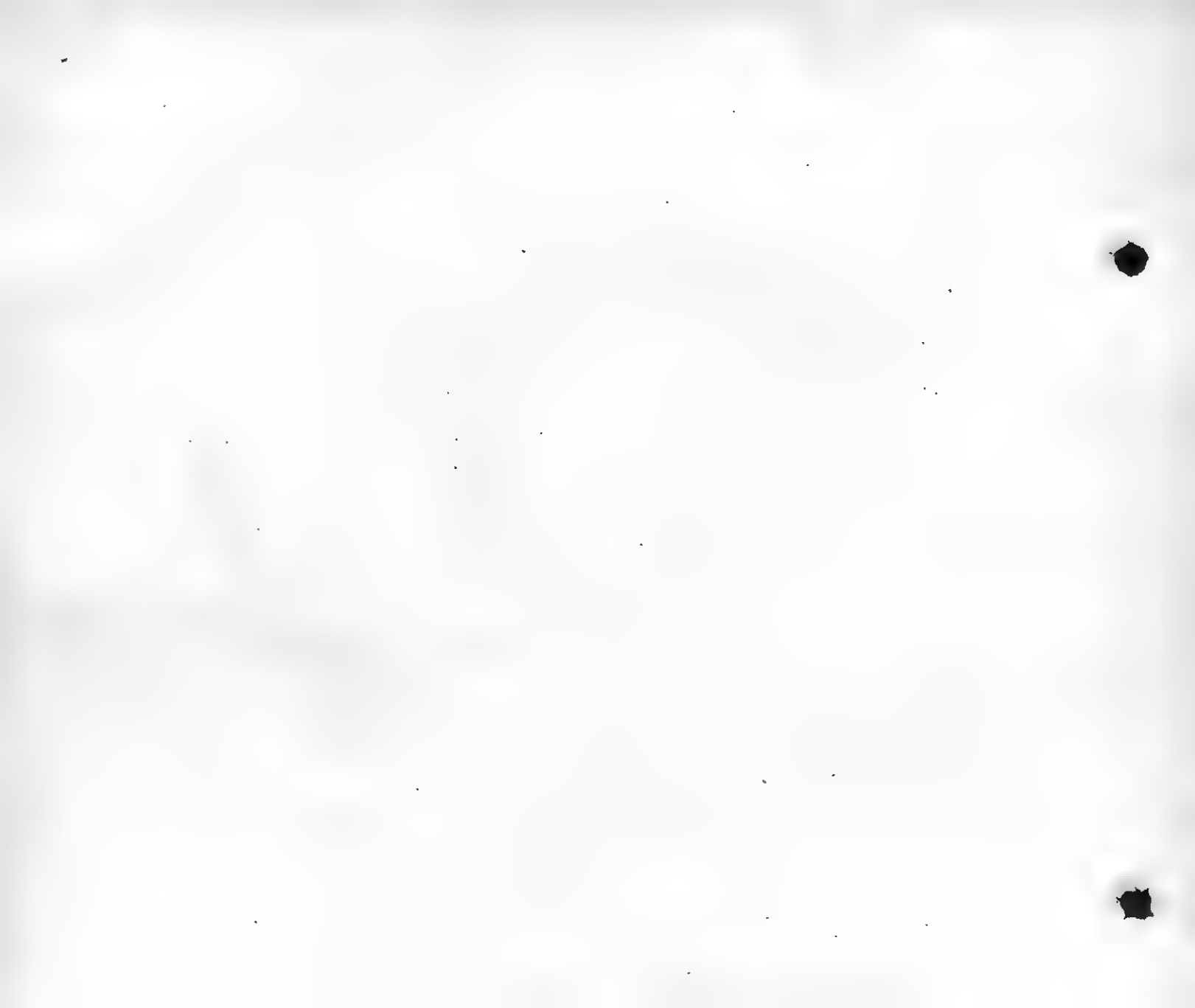
VS A15 (4)
15M 9/58

7497

CERTIFICATE OF DEATH

Reg. Dist. No. 07488

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>CC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burlesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>234 Arundel Rd</u>		d. STREET ADDRESS <u>206 Arundel Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>W</u> Last <u>Gibbons Sr</u>		4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1, 1882</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours M n	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Brooklyn N.Y.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>UNK.</u>		14. MOTHER'S MAIDEN NAME <u>UNK</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive cardiovascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1959</u> to <u>July 7, 1961</u> that I last saw the deceased alive on <u>July 6, 1961</u> and that death occurred at <u>7 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip W. Keister, M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>302 Patapoco Ave</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>PHILIP W. KEISTER M.D.</u>		<u>Baltimore, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7-11-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Comfort Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Alexandria Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mc Gilly Funeral Home</u> ADDRESS <u>130 E. L. Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 10 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7498

CERTIFICATE OF DEATH

07489

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN b. 9 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Millersville d. STREET ADDRESS Rt-2, Box-60 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lorey Middle GREEN Last GREEN 4. DATE OF DEATH Month July Day 3 Year 1961		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Oct. 24, 1897 9. AGE (In years, last birthday) 63 yrs. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Self-Employed 11. BIRTHPLACE (Country & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Charles Green 14. MOTHER'S MAIDEN NAME Mrs. Geneva Green - Same As #2	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. unknown 17. INFORMANT Mrs. Geneva Green - Same As #2 Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with widespread metastases DUE TO 1st Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 6 mos DUE TO 6 mos PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Hour 11 m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) Richard N. Peeler attended the deceased from 11/1 19 61 to 7/3 19 61 , that (I) yes last saw the deceased alive on 7/3 19 61 , and that death occurred at 3:30 PM from the causes and on the date stated above. 22a. SIGNATURE Richard N. Peeler M.D. 22c. PHYSICIAN'S NAME (Type) Richard N. Peeler		22b. DATE SIGNED 7/3/61 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 6th July 1961 23c. NAME OF CEMETERY OR CREMATORY Baldwin Mem. Ch. Cem. 23d. LOCATION (City, town or county) (State) Millersville, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Richard V. Singleton ADDRESS Glen Burnie, Md. 25a. REC'D BY REGISTRAR JUL 7 - 1961 25b. REGISTRAR'S SIGNATURE Walter L. Kinnard	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7499 CERTIFICATE OF DEATH

Reg. Dist. No. **07490**

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Box 222 Severn Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alexina Louise Gregory				4. DATE OF DEATH Month 7 Day 11 Year 61			
5. SEX Female		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 1	
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Nathaniel Jackson				14. MOTHER'S MAIDEN NAME Isabella			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Fred Gregory			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertensive Cardio Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1961, to July 11, 1961, that I last saw the deceased alive on 7-8-61, and that death occurred at 8:00 PM, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Richard H. Hunt M.D. 100 Cherry Lane, Glen Burnie, 7-10-61							
ACTUAL SIGNATURE Richard H. Hunt							
PHYSICIAN'S NAME (Type) Richard H. Hunt							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-15-61		22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem		22d. LOCATION (City, town, or county) (State) Anne Arundel Co	
23. FUNERAL DIRECTOR'S SIGNATURE Chas O Wilson				24a. REC'D BY REGISTRAR DATE JUL 27 '61		24b. REGISTRAR'S SIGNATURE Charles E. Thomas	



7500

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07491

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>18 Brice Drive</u>		d. STREET ADDRESS <u>1 18 Brice Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Mabel L. Griffiths</u>		4. DATE OF DEATH <u>July 31 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1888</u>
9. AGE (In years last birthday) <u>73</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Maurice S. Warner</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Barry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JOHN E. Griffiths</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/31 1961</u> to <u>7/31 1961</u> , that (I) (we) last saw the deceased alive on <u>7/31 1961</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Gerard Church</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>GERARD CHURCH</u>		22d. ADDRESS <u>121 CATHELAN ST ANNAPOLIS MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-3-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Abbingtton Hills</u>		23d. LOCATION (City, town, or county) (State) <u>Clark Summit Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Saylor & Sons Annapolis, Md</u>		25a. REC'D BY REGISTRAR <u>AUG 2 '61</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be noted in the certificate. The certificate should be executed in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7501 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07492

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Potapsco Park</u> c. LENGTH OF STAY in b <u>one hour</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 17</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Body of water in Arundel Quarry</u>			d. STREET ADDRESS <u>1513 Linden Ave.</u>		
3. NAME OF DECEASED (Type or print) <u>Bernard D. Gross</u>			4. DATE OF DEATH <u>July 6th.</u> 1961		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/23/31</u>		9. AGE (In years last birthday) <u>30</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Frank Watson</u>			14. MOTHER'S MAIDEN NAME <u>Gladys Gross</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Korean War</u>			17. INFORMANT <u>Mrs. Gladys Gross (mother)</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental drowning</u> DUE TO Conditions, if any which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO (e), stating the underlying cause last. (c) <u></u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Was swimming when he suddenly disappeared under the water.</u>		
20c. TIME OF INJURY Month, Day, Year <u>4.30 p.m. 7/6/61 19</u>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Arundel Quarry</u>		
20f. (City or town) <u>Potapsco Park, A.A. Md.</u>			20g. (County) <u></u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 7/6/61 DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>7-10-61</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>St. Anselm</u>			22d. LOCATION (City, town, or country) <u>Glen Burnie, Md.</u>		
23. FUNERAL DIRECTOR <u>Rev. S. Nelson 1348 N. Calhoun St</u>			24a. REC'D BY REGISTRAR <u>JUL 10 '61</u>		
			24b. REGISTRAR'S SIGNATURE <u>Shen L. Kraw</u>		



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be explained in the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7502 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07493	
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>						c. LENGTH OF STAY in 1b <u>10 days</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1907 Norman Rd.</u>						d. STREET ADDRESS <u>Same</u>					
3. NAME OF DECEASED (Type or print) <u>James Patrick Groves</u>						4. DATE OF DEATH <u>July 8th</u> 19 <u>61</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/17/60</u>		9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>San Angelo, Texas</u>					
11. BIRTHPLACE (State or foreign country) <u>USA</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Robert Groves</u>						14. MOTHER'S MAIDEN NAME <u>Patricia Kirby</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>Mr. Robert Groves (father)</u>					
17. INFORMANT <u>Mr. Robert Groves (father)</u>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Strangulation</u>											
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO											
DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Was in his crib and was playing with the venetians blind cord and accidentally looped around his neck.</u>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>4</u> <u>7/8/61</u> 19 <u>Home</u> <u>Glen Burnie, A.A. Md.</u>											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> <u>Home</u> <u>Glen Burnie, A.A. Md.</u>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> <u>Glen Burnie, A.A. Md.</u>											
20f. (City or town, (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7/8/61</u>											
Address (Street, city, town, or county) <u>Glen Burnie, Md.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>July 13 1961</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Deer Creek Cemetery</u> 22d. LOCATION (City, town, or county) <u>Decatur, Alabama</u> (State)											
23. FUNERAL DIRECTOR <u>Hopping - HIRSHLEY, Glen Burnie, Md.</u> 24a. REC'D BY REGISTRAR <u>DA JUL 12 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											



TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be noted in the space provided. To execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7503 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07494

1. PLACE OF DEATH a. COUNTY <u>A.A.C.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AACO</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS MD</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1700 A. ANNE ARUNDEL GEN.</u>		d. STREET ADDRESS <u>1 RED-BOX 107</u>	
3. NAME OF DECEASED (Type or print) <u>John NEIMAN</u>		4. DATE OF DEATH Month <u>7</u> Day <u>23</u> Year <u>61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-5-1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>	
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JAMES A HALL</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH ANNE NEIMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>JOSEPH G. NEIMAN</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>812X</u> DUE TO <u>Multiple Myeloma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Just prior</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car accident - Chest struck by auto</u>	
20c. TIME OF INJURY Month <u>7</u> Day <u>23</u> Year <u>61</u> Hour <u>8</u> a.m. <u>8</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>St. Margaret's MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		DATE SIGNED <u>7-23-61</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		DEPUTY MEDICAL EXAMINER <u>R</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-26-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Margaret's Cent</u>		22d. LOCATION (City, town, or country) (State) <u>St. Margaret's ACO MD</u>	
23. FUNERAL DIRECTOR <u>John M. Saylor Sons</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Harris</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>		DATE <u>JUL 26 '61</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7504

07495

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN b. 4 mo, 16 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 401 E Federal St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle B. Last Harrison		4. DATE OF DEATH Month 7 Day 29 Year 1961	
5. SEX Male		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/27/1888	
9. AGE (in years last bday) 72 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 29 Hours 1 Min. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Harrison		14. MOTHER'S MAIDEN NAME Meivena Harrison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure Conditions: Arteriosclerotic and Syphilitic Cardio-vascular Disease with Hypertension (a), stating the underlying cause last. (b) gave rise to immediate cause (c) due to			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome assoc. with Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/14 , 19 61 to 7/29 , 19 61 that (I) (we) last saw the deceased alive on 7/29 , 19 61 , and that death occurred 2:10 a.m. on the causes and on the date stated above.			
22a. SIGNATURE Enrique V. del Campo		22b. DATE SIGNED July 29/61	
22c. PHYSICIAN'S NAME (Type) Enrique V. del Campo		22d. ADDRESS Crownsville State Hospital Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE OF REMOVAL 8-2-61	
23c. NAME OF CEMETERY OR CREMATORY Gardens of Eternal Hope		23d. LOCATION (City, town or county) (State) Finksburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Marshall W. Jones, Jr.		25. REGISTRAR'S SIGNATURE Arthur S. Frank	
3001-D Seabury Rd.		AUG 9 1961	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7505

CERTIFICATE OF DEATH

Reg. Dist. No.

07496

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. LENGTH OF STAY IN 1b <u>14 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KIMBROUGH ARMY HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUAL</u> <u>HEATON JR</u>		4. DATE OF DEATH Month Day Year <u>JULY</u> <u>10</u> <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 July 1961</u>
9. AGE (In years last birthday) <u>14</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rual Heaton</u>		14. MOTHER'S MAIDEN NAME <u>Marilyn Heaton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mother-Savage & Guilford Rd Jessup, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>77 1/2</u> DUE TO (c) <u>77 1/2</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 July</u> , 19 <u>61</u> , to <u>10 July</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>10 July 61</u> , 19 <u>61</u> , and that death occurred at <u>5:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sherman S. Robinson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kimbrough Army Hosp Ft Geo G. Meade, Md</u>	
PHYSICIAN'S NAME (Type) <u>SHERMAN S. ROBINSON, Capt., M.C.</u>		DATE SIGNED <u>11 Jul 61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-13-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beth Nat. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beth City</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl B. Holmstrom</u>		24. REC'D BY REGISTRAR <u>Jul 31 '61</u>	
ADDRESS <u>6306 Belvoir Rd</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

1

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

750S

CERTIFICATE OF DEATH

07497

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN IL 4 yrs. 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 535 Dolphin Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lucinda		First Lucinda		Middle White		Last Hines	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 10, 1874	
				9. AGE (In years last birthday) 86		10. IF UNDER 1 YEAR Months 7 Days 17	
				11. BIRTHPLACE (County & State, or foreign country) Albany, Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Albany, Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony White		14. MOTHER'S MAIDEN NAME Charlotte ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
				17. INFORMANT Hospital Records		Address -----	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Arteriosclerotic Cardiovascular Renal Disease (c), stating the underlying cause last. -----		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH -----			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia; Fecal Impaction							
20a. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20d. (City or town) -----	
20e. (County) -----		20f. (State) -----		20g. (City or town) -----		20h. (County) -----	
20i. (State) -----							
21. I certify that (I) (this hospital) attended the deceased from 7/13 1957 to 7/17 1961 that (I) (we) last saw the deceased alive on 7/17 1961 , and that death occurred at 7:00 A.M. from the causes and on the date stated above							
22a. SIGNATURE Hildegard Heard Reissman		22b. DATE SIGNED 7/17/61		22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 7/23/61		23b. NAME OF CEMETERY OR CREMATORY St. Ignace Cemetery		23c. LOCATION (City, town or county) AA County Md		23d. (State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE A. Halstead		ADDRESS 918 E. Main St.		25a. RECD BY REGISTRAR DATE JUN 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7507
CERTIFICATE OF DEATH
07498

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN lb 1 1/2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park d. STREET ADDRESS 207 Sycamore Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cari Frances HOCK		4. DATE OF DEATH Month July Day 18 Year 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1961	
9a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Francis Hock, Jr.		14. MOTHER'S MAIDEN NAME June Charlotte Harting	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Asphyxia Neonatorum PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) Hospital records			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (we) attended the deceased from July 17, 1961 to July 18, 1961 , that (I) (we) last saw the deceased alive on July 18, 1961 , and that death occurred at 6:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Clayton Norton		22b. DATE SIGNED 6:45 P.M.	
22c. PHYSICIAN'S NAME (Type) Dr. Clayton Norton		22d. ADDRESS Medical Building, Severna Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/20/61	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 8, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101		25a. REC'D BY REGISTRAR JUL 24 '61	
ADDRESS Edmondson Ave.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7508

CERTIFICATE OF DEATH

Reg. Dist. No. **07499**

1. PLACE OF DEATH a. COUNTY <u>ORUNDE L</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Ind</u> b. COUNTY _____							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>10 yrs?</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Rt 2 Box 423</u>				d. STREET ADDRESS <u>746 Washington Blvd</u>							
3. NAME OF DECEASED (Type or print) First <u>OTTO</u> Middle <u>A.</u> Last <u>HOFMANN</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>7</u> Year <u>1961</u>							
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/1900</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____						
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Flower Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>For Self</u>		11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>							
13. FATHER'S NAME <u>Edward L. Hoffmann</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Rheinland</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u> </u>		INFORMANT Address <u>746 Wash. Blvd</u> <u>Mrs Anna V. Hoffmann</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <table style="width: 100%;"> <tr> <td style="width: 30%;"> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>152X</u> DUE TO <u>Carcinomatosis.</u> </td> <td style="width: 70%;"></td> </tr> <tr> <td> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. </td> <td> (b) <u>Ca. of lung.</u> </td> </tr> <tr> <td></td> <td> (c) _____ </td> </tr> </table>						PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>152X</u> DUE TO <u>Carcinomatosis.</u>		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	(b) <u>Ca. of lung.</u>		(c) _____
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>152X</u> DUE TO <u>Carcinomatosis.</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	(b) <u>Ca. of lung.</u>										
	(c) _____										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) _____		(County) _____		(State) _____							
21. I certify that I attended the deceased from <u>July 6</u> , 19 <u>61</u> , to <u>July 7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>61</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Edmond I. Moushabek</u> M.D.				DATE SIGNED <u>7/7/61</u>							
PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABEK, Glen Burnie, Md.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/10/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem.</u>							
22d. LOCATION (City, town, or county) _____		(State) _____									
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan & Son</u>				ADDRESS <u>Hallins St.</u>							
24a. REC'D BY REGISTRAR <u>DATE</u> <u>10/61</u>		24b. REGISTRAR'S SIGNATURE <u> </u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If an please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7509

CERTIFICATE OF DEATH

07500

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rivera Beach</u> c. LENGTH OF STAY IN 1b <u>years?</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>243 Glenwood Rd.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md.</u> f. COUNTY <u>Anne Arundel</u> g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rivera Beach</u> h. STREET ADDRESS <u>243 Glenwood Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Ruth</u> <u>Hummer</u>		4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1961</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>11/2/1891</u>		9. AGE (in years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u>			
14. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		15. MOTHER'S MARRIAGE NAME <u>Elizabeth Schwaker</u>		16. SOCIAL SECURITY NO. <u>21822407</u>			
17. INFORMANT <u>Mr Elmer Emerst</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma lung</u> (b) <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> <u>1961</u> , to <u>July 28</u> <u>1961</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>July 28</u> <u>1961</u> , and that death occurred at <u>6:20 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>J. Brady Smith</u>		22b. DATE SIGNED <u>7/29/61</u>		22c. PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>			
22d. ADDRESS <u>RIVERA BEACH, PASADENA, MD.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> <u>8/1/61</u>					
23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		23d. LOCATION (City, town or county) <u>Woodlawn</u> <u>MD.</u>			
23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE <u>John J. Cowan</u>		23g. DATE <u>Aug 1 61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7510

07501

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE MD b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cakey Forest		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X54w Luther P Key	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 54 w Luther P Key		d. STREET ADDRESS 100 Cakey Forest	
3. NAME OF DECEASED (Type or print) First Shelley M dle D Last Hutchinson		4. DATE OF DEATH Month 7 Day 13 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 19-1864 96 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10b. KIND OF BUSINESS OR INDUSTRY off salute Mich. U.S.	
11. BIRTHPLACE (State or foreign country) off salute Mich. U.S.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Stephen Hutchinson		14. MOTHER'S MAIDEN NAME Zoretta	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 450.0 DUE TO Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 19 to 1961 19 that (I) (we) last saw the deceased alive on 7-13-61 19 and that death occurred at 4:15 P. M. from the causes and on the date stated above			
22a. SIGNATURE Robert R. Holm M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Print) Robert R. Holm		22d. ADDRESS Severna Park Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) B		23b. DATE THEREOF 7-18-61	
23c. NAME OF CEMETERY OR CREMATORY Highland Cem.		23d. LOCATION (City, town, or county) (State) Hyattsville, Michiga	
24. FUNERAL DIRECTOR'S SIGNATURE Michael J. ... ADDRESS		25a. REC'D BY REGISTRAR DATE JUL 17 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. ...	



7512

MEDICAL CERTIFICATION

may be retained by the hospital or attending physician.

TO FILE WITH THE DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the certificate must be filed with the Director of Health. The certificate must be filed with the Director of Health in the same manner as the certificate filed with the funeral director, and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

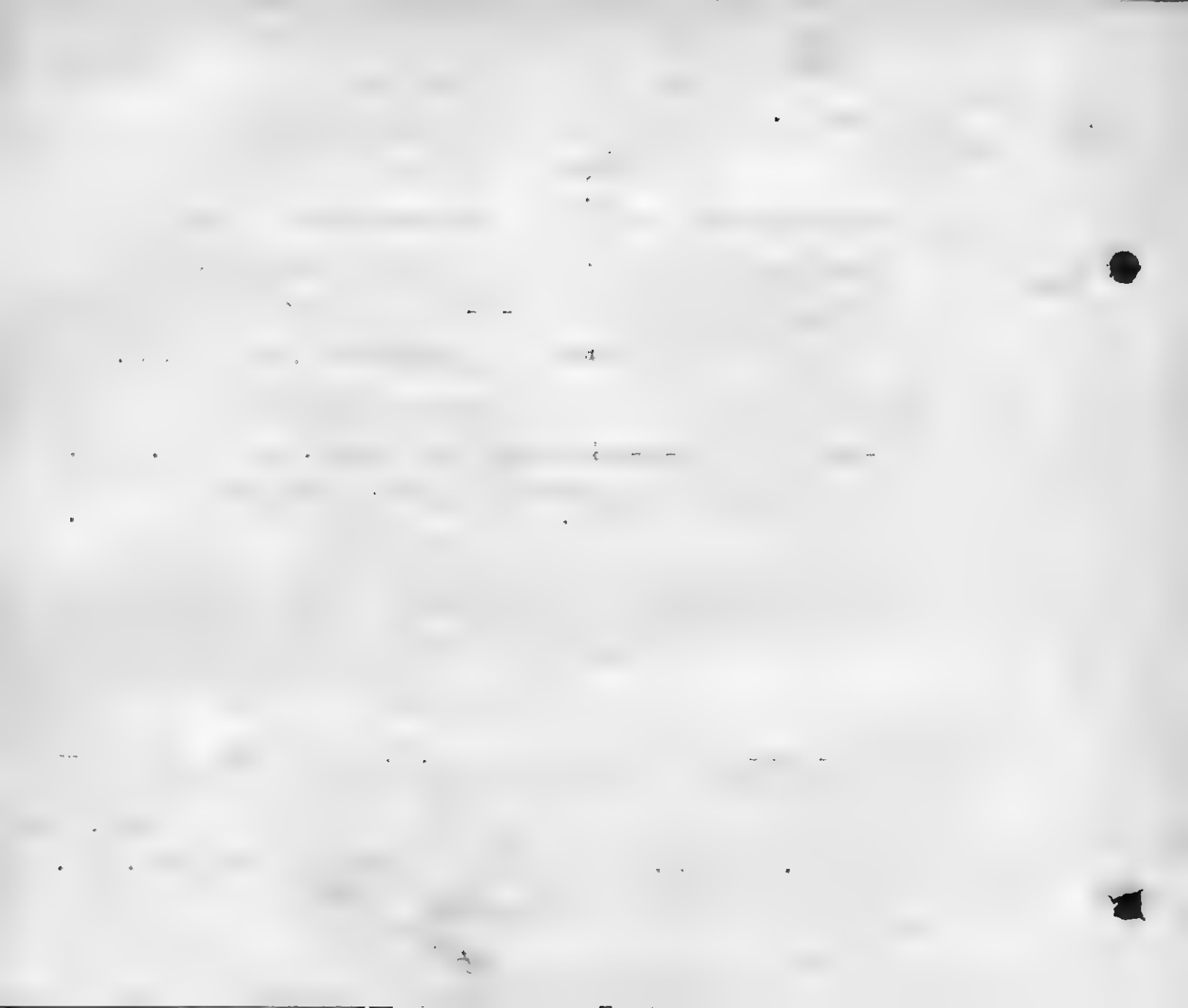
7512

CERTIFICATE OF DEATH

07503

Item 8 - Film G-91 7/26/61 iwk

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN b 11 months		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1106 Argyle Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Anna Jones		4. DATE OF DEATH July 16, 1961		5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1895 7-7-1895		9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic worker		11. BIRTHPLACE (County & State, or foreign country) Northumberland Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi Campbell		14. MOTHER'S MAIDEN NAME Charlotte Washington		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-26-8253		17. INFORMANT Malissa Jones		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardio vascular disease with aortic stenosis. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH ? yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from August 21, 1960 to July 16, 1961 that (I) (we) last saw the deceased alive on July 8, 1961 , and that death occurred at p.m. from the causes and on the date stated above.														22b. DATE SIGNED July 17, 1961					
22a. SIGNATURE James M. Pair						M.D. James M. Pair, M.D.		22c. ADDRESS 400 N. Carrollton Avenue Balto. 23, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)													
Burial		July 19-61		Church Cemetery		Lottsburg Va.													
24. FUNERAL DIRECTOR'S SIGNATURE V. Brooks Ruggold						ADDRESS 1463 N. Carey St.		25. REC'D BY REGISTRAR JUL 19 '61		25b. REGISTRAR'S SIGNATURE James S. Thomas									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7513

CERTIFICATE OF DEATH

07504

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>F.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOIS</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOMEWOOD NURSING HOME</u>		d. STREET ADDRESS <u>EDGEWATER</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Clifton</u> Last <u>KEESER</u>		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-1866</u>
9. AGE (In years last birthday) <u>95</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>LUMBERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plant Supervisor</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>"UNK"</u>		14. MOTHER'S MAIDEN NAME <u>"UNK"</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>233-20-0391</u>	
17. INFORMANT <u>Mrs. Harry R. King</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1956</u> to <u>30 JULY 1961</u> , that (I) (we) last saw the deceased alive on <u>30 JULY 1961</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u> M.D.		22b. DATE <u>JULY 31 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		22d. ADDRESS <u>73 FRANKLIN ST. ANNAPOLIS MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-2-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Valley View Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>HARRISBURG W. VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 2 61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7514 **CERTIFICATE OF DEATH**

07505

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>14</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park.</u>				c. LENGTH OF STAY IN 1b <u>2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Manor Rd.</u>				e. STREET ADDRESS <u>1 Severna Park wick</u>			
3. NAME OF DECEASED (Type or print) First <u>Max</u> Middle <u>John</u> Last <u>Kehm.</u>				4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1961</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 24, 1894</u>	9 AGE (In years last birthday) <u>67</u> yrs	IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u> Hours <u>6</u> Min. <u>7</u>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery.</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mathias Kehm.</u>				14. MOTHER'S MAIDEN NAME <u>Anna Seifz</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-30-6701</u>		17 INFORMANT <u>Mrs. Katherine Kehm</u> Address <u>1431 Decatur St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>16-2X</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>1961</u> , that (i) (we) last saw the deceased alive on <u>7-3-61</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert R. Halpin</u>				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Halpin</u>				22d. ADDRESS <u>Severna Park wick</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7-6-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Stevens</u>				25a. RECD BY REG. STR. DATE <u>JUL 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

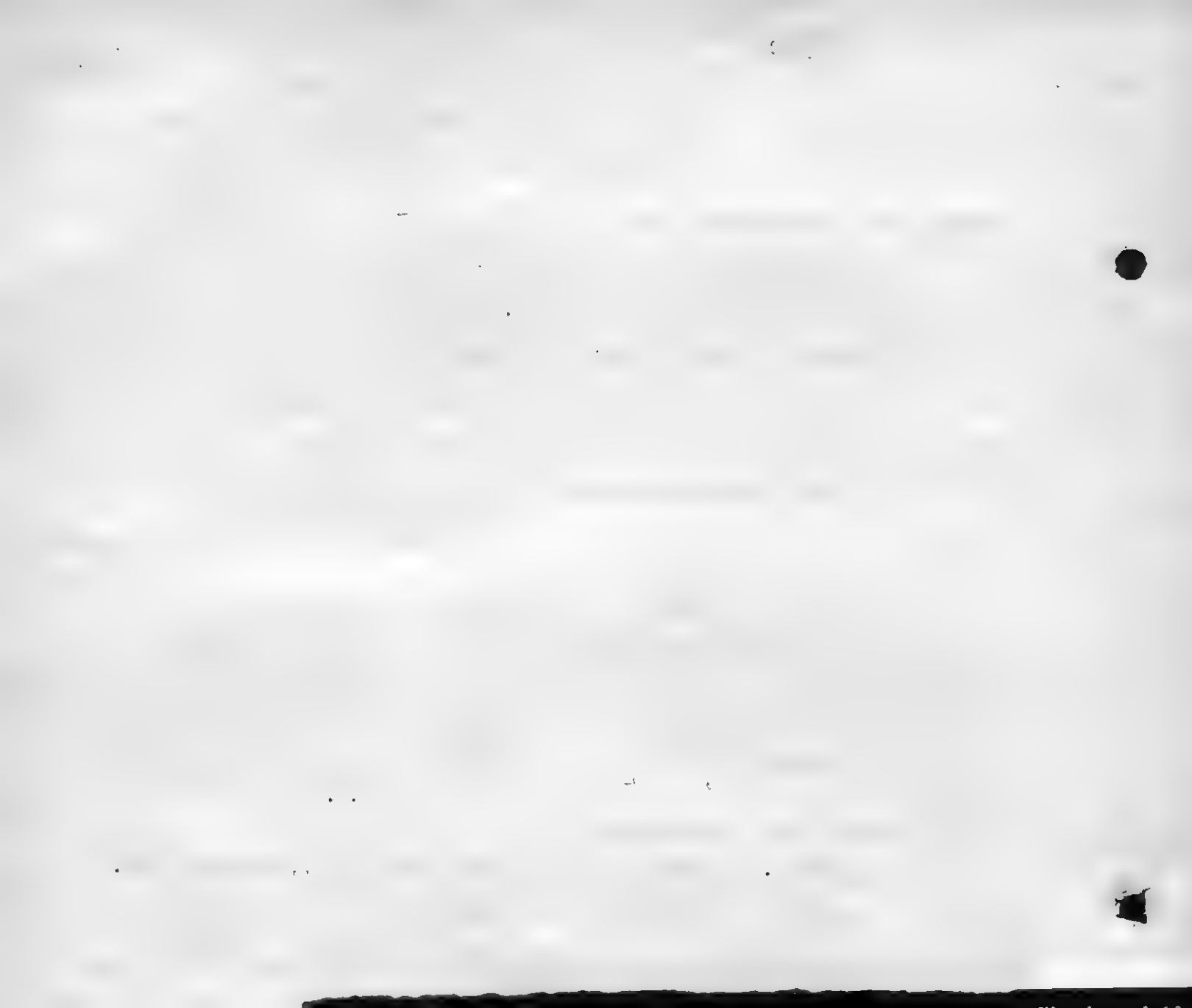
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07507

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN TB 9 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Riva d. STREET ADDRESS Box-7 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stanley 4. DATE OF DEATH July 10 1961		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 24, 1897 9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic 10b. KIND OF BUSINESS OR INDUSTRY Automobiles 11. BIRTHPLACE County & State, or foreign country Lithuania 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Deceased 14. MOTHER'S MAIDEN NAME Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 16. SOCIAL SECURITY NO. W.W.I. 217-24-9373 17. INFORMANT RECORDS Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO (b) Pulmonary and pleural metastases DUE TO (c) Carcinoma of tongue Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Lymphatic Leukemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 1 week 3 months 1 1/2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from July 1, 1961 to July 9, 1961 , that (I) (we) last saw the deceased alive on July 9, 1961 , and that death occurred at 1:55 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman 22c. PHYSICIAN'S NAME (Type) Richard I. Hochman		22b. DATE SIGNED 22d. ADDRESS 100 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 12/5/4/1961 23c. NAME OF CEMETERY OR CREMATORY Balto National 23d. LOCATION (City, town or county) (State) Fredrick MD Md		24. FUNERAL DIRECTOR'S SIGNATURE Charles W. Hochman 25a. REC'D BY REGISTRAR JUL 13 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kiana	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7517
CERTIFICATE OF DEATH

07508

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>JESSUPS</u> c. LENGTH OF STAY IN <u>MD.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>JESSUPS RD.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>JESSUPS</u> d. STREET ADDRESS <u>1 JESSUPS RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>M.</u> Last <u>KNIGHT</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 25, 1905</u>
9. AGE (in years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR: Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MGR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BICUIT CO.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>FRANK L. KNIGHT</u>		14. MOTHER'S MAIDEN NAME <u>MARY J. NORTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Failure</u> DUE TO (b) <u>Hypertensive Cardio-Vas. Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last: <u>Diabetes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u> <u>2 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 21, 1961</u> to <u>July 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 21, 1961</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank E. Shipley, M.D.</u>		22b. DAY SIGNED <u>7/23/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D.</u>		22d. ADDRESS <u>Savage, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-24-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE CEM.</u>		23d. LOCATION (City, town or county) (State) <u>ELBRIDGE MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Julius Cavaraugh, F.H. - Catonsville, Md.</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>JUL 27 '61</u>		DATE <u>JUL 27 '61</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

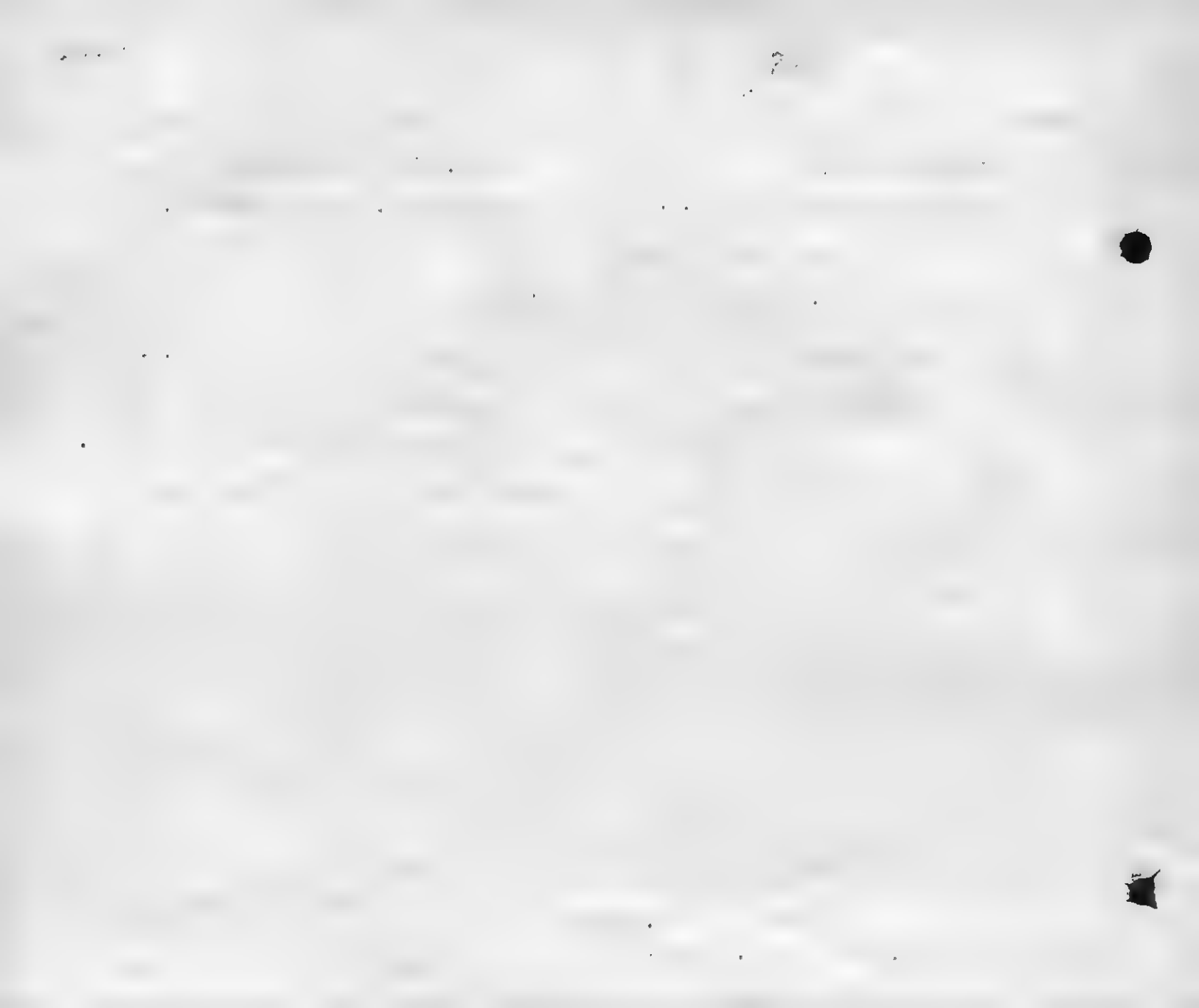
CERTIFICATE OF DEATH

7518

07509

1. PLACE OF DEATH COUNTY <u>Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Andover & Maryland ave., P.O. Box 230</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Linthicum Heights</u> d. STREET ADDRESS <u>Maryland Ave., Near Andover Rd.</u>					
3. NAME OF DECEASED (Type or print) <u>Joseph (Joe) Knox</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1961</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/13/1894</u>				
9. AGE (In years last birthday) <u>66</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months Days	Hours Min.						
11. BIRTHPLACE (County & State, or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-16-4105</u>					
17. INFORMANT <u>Julia Knox</u>		18. ADDRESS <u>Maryland Ave. & Andover Rd.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AC CEREBRAL VASCULAR ACCIDENT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DIS</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (i) (this hospital) attended the deceased from....., 19....., to....., 19.....; that (i) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M., from the causes and on the date stated above.							
22a. SIGNATURE <u>John S. Branton Jr.</u> M.D.		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. BRANTON JR.</u>		22d. ADDRESS <u>922 S. SHARP.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/6/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Rice</u>		25a. REC'D BY REGISTRAR <u>DAVID L 12 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7510 CERTIFICATE OF DEATH

07510

1. PLACE OF DEATH o COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLERSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lombardy Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Knollwood Manor Nursing		d. STREET ADDRESS Route 1 Box 212 Nabbs Creek	
3. NAME OF DECEASED (Type or print) IDA M. Kuhl		4. DATE OF DEATH Month July Day 5 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1901
9. AGE (In years lost birthday) 60 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) MARYLAND
10b. KIND OF BUSINESS OR INDUSTRY Domestic		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Bowers		14. MOTHER'S MAIDEN NAME Elizabeth Weinberg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-01-3145	
17. INFORMANT Address Route 1 Box 212 Elizabeth Niemeyer Nabbs Creek Rd		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Heart Disease (c) Cerebrovascular accident		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 years 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 20, 1952 to July 5, 1961 , that (I) (we) last saw the deceased alive on July 3, 1961 , and that death occurred at 1 P. M. from the causes and on the date stated above.			
22a. SIGNATURE R. M. McLaughlin		22b. PHYSICIAN'S NAME (Type) R. M. McLaughlin	
22c. PHYSICIAN'S NAME (Type) R. M. McLaughlin		22d. ADDRESS 3708 Mountain Rd. Pasadena, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7-10-61	23c. NAME OF CEMETERY OR CREMATORY LONDON PARK	23d. LOCATION (City, town, or county) (State) BALTIMORE, Md
24. FUNERAL DIRECTOR'S SIGNATURE George L. Schwab Funeral Home		25a. REC'D BY REGISTRAR Francis H. Miller 2101 Federal Ave	
25b. REGISTRAR'S SIGNATURE July 8 1961		25c. DATE JUL 10 1961	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7520 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07511

FOR STATE HEALTH DEPT.

This certificate should be executed within 24 hours after death. Any delay is necessary, a funeral director, Page 1, 2, and 3 may be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>ANNO</u> b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>ANNE ARUNDEL CO</u> c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>D.O.A. ANNE ARUNDEL GEN.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1</u> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>TAKOMA PARK K 55-2</u> d. STREET ADDRESS <u>7404-16th. CR</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>goldman</u> First <u>C</u> Middle <u>E</u> Last <u>Laden</u> 4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1961</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-1-10</u> 9. AGE (In years last birthday) <u>50</u> yrs. FUNDER 1 YEAR <u>50</u> Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman automatic machines</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Idabelle, Okla</u> 11. BIRTHPLACE (State or foreign country) <u>Idabelle, Okla</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Roland C. Laden</u> 14. MOTHER'S MAIDEN NAME <u>Mary Riggs</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>579-03-8950</u> 17. INFORMANT Address <u>1704 16th Ave. Mrs. Vera Moseley Laden Takoma Pk, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Choke</u> DUE TO <u>1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Choke</u> DUE TO <u>1</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10</u> p.m. <u>4</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>7-29.61</u>	
22a. BURIAL, CREMATION, or other disposition <u>burial</u> 22b. DATE THEREOF <u>8/1/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Washington Cemetery</u> ADDRESS <u>Wash. DC</u> 22d. LOCATION (City, town, or country) (State) <u>Pr. Geo. Co., Maryland</u>		23. FUNERAL DIRECTOR <u>The S.H. Hines Co., 2901 14th St. N.W.</u> 24a. REC'D BY REGISTRAR <u>AUG 2 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

MEDICAL CERTIFICATION

1
FOR STATE
HEALTH DEPT. (M)
X
1
DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7521 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07512

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore County</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 22</u>	
c. LENGTH OF STAY IN b. <u>3 hours</u>		d. STREET ADDRESS <u>207 Parkwood Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Martin Co. Office Building</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herbert Larrimore</u>		4. DATE OF DEATH <u>7/25/61</u> 19	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/2/16</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rockhall, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William R. Larrimore</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Margaret Frost</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes, World War # 2</u>		16. SOCIAL SECURITY NO. <u>213-07-7874</u>	
17. INFORMANT <u>Mrs. Lilian M. Larrimore</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7-28-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Catonsville, Md.</u>	
23. FUNERAL DIRECTOR <u>Ullrich Funeral Home, Dundalk, Md.</u>		24a. REC'D BY REGISTRAR <u>DAHL 7 7</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>		DATE SIGNED <u>7/25/61</u> <u>Glen Burnie, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7522
CERTIFICATE OF DEATH

07513

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 16 <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>136 Riverview Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>R.</u> Middle <u>LOFTUS</u> Last <u>LOFTUS</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 29, 1892</u>	
9. AGE (In years last birthday) <u>68 yrs.</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAREHOUSE SUPT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE W LOFTUS</u>		14. MOTHER'S MAIDEN NAME <u>CLARA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>World War I</u>	
17. INFORMANT <u>ELSIE M. LOFTUS</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary artery Disease</u> (a), stating the underlying cause last. DUE TO (c) <u>11 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>4:40 P.M.</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (physician) attended the deceased from... 1954, 19... 7-21-61, that (I) (not) last saw the deceased alive on... 6-6-61, 19... M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Shiple</u>		22b. DATE SIGNED <u>7-24-61</u>	
22c. PHYSICIAN'S NAME <u>FRANK M-SHIPLEY</u>		22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-25-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Annapolis National</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>		25a. REC'D BY REGISTRAR <u>JUL 26 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7523

CERTIFICATE OF DEATH

07514

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 10 days		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital	
3. NAME OF DECEASED (Type or print) Lois M. LONG		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher		10b. KIND OF BUSINESS OR INDUSTRY Schools		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Merton Long		14. MOTHER'S MAIDEN NAME Maude Yeigh		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Janet A. Long, Mifflintown, Pa.	
17. INFORMANT Janet A. Long, Mifflintown, Pa.		18. CAUSE OF DEATH (Enter only one cause pertinent for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the DUE TO Liposarcoma of Ovary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Librosarcoma of Ovary DUE TO Librosarcoma of Ovary DUE TO Librosarcoma of Ovary		INTERVAL BETWEEN ONSET AND DEATH 3 months 6 months		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour s.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this physician) attended the deceased from June 11, 1961 to July 11, 1961 , that (I) (we) last saw the deceased alive on June 11, 1961 , and that death occurred at 8:45 PM , from the causes and on the date stated above.		22a. SIGNATURE James R. Martin	
22b. DATE SIGNED 7-11-61		22c. PHYSICIAN'S NAME (Type) JAMES R. MARTIN		22d. ADDRESS 6 SHAW ST, ANNAPOLIS, MD.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/13/61		23c. NAME OF CEMETERY OR CREMATORY Old Church Hill Cemetery		23d. LOCATION (City, town or county) (State) Port Royal, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		24b. ADDRESS		25a. REC'D BY REGISTRAR JUL 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

TO VITAL RECORDS: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.

After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7524

07515

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>1 yr. 1 mo 1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>204 Wintertane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>James W. Lowman</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1961</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/28/1870</u>	9. AGE (In years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR Months <u></u> Days <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cochman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Livery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		
13. FATHER'S NAME <u>William Burkett</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Lowman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Medical Records</u> Address <u></u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure and Uremia</u> <u>331X</u> DUE TO <u>CVA</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last: } DUE TO <u>General Arteriosclerosis + Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with General arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>		
20c. TIME OF INJURY Hour a.m. <u></u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>6/15/61</u>	20f. (City or town) <u>Catonsville</u> (County) <u></u> (State) <u></u>	20g. (City or town) <u>19/29/61</u>
21. I certify that (I) (this hospital) attended the deceased from <u>6/15/61</u> to <u>7/29/61</u> , that (I) (we) last saw the deceased alive on <u>9/29/61</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.				
22a. SIGNATURE <u>James W. Lowman</u>		22b. DATE SIGNED <u>9/29/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Henry Mapp</u>
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial 8-1-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>White Rock</u>		23d. LOCATION (City, town, or county) <u>Catonsville, Md.</u> (State) <u></u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>		25a. REG. BY REGISTRAR <u>61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Kraws</u>



1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed by the funeral director, or by a physician, or by a coroner, or by a medical examiner, or by a health officer, or by a designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film 293 8

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7525 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07516

Item 7 Film 293 8

1. PLACE OF DEATH
a. COUNTY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oyster Harbor
c. LENGTH OF STAY IN 1b 1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Pennsylvania
b. COUNTY Philadelphia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia
d. STREET ADDRESS 5834 Delancey Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First MALCOLM Middle ARTHUR Last MARTIN

4. DATE OF DEATH
Month July Day 31 Year 19 61

5. SEX Male

6. COLOR OR RACE Colored

7. MARRIED ☐ NEVER MARRIED ☒

8. DATE OF BIRTH 2-7-1939

9. AGE (In years last birthday) 22 yrs. IF UNDER 1 YEAR Months 22 Days 22 IF UNDER 24 HRS. Hours 22 Min. 22

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook
10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania U.S.A
11. BIRTHPLACE (State or foreign country) Pennsylvania U.S.A
12. CITIZEN OF WHAT COUNTRY U.S.A

13. FATHER'S NAME Ronald S. Martin
14. MOTHER'S MAIDEN NAME Edith Gardner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. Ronald S. Martin Phila. 43-PA
17. INFORMANT Ronald S. Martin Address Phila. 43-PA

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning
929.8 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Acute alcoholism
(c) Found drowned
DUE TO
cause last. (c) Found drowned

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).
Acute alcoholism

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

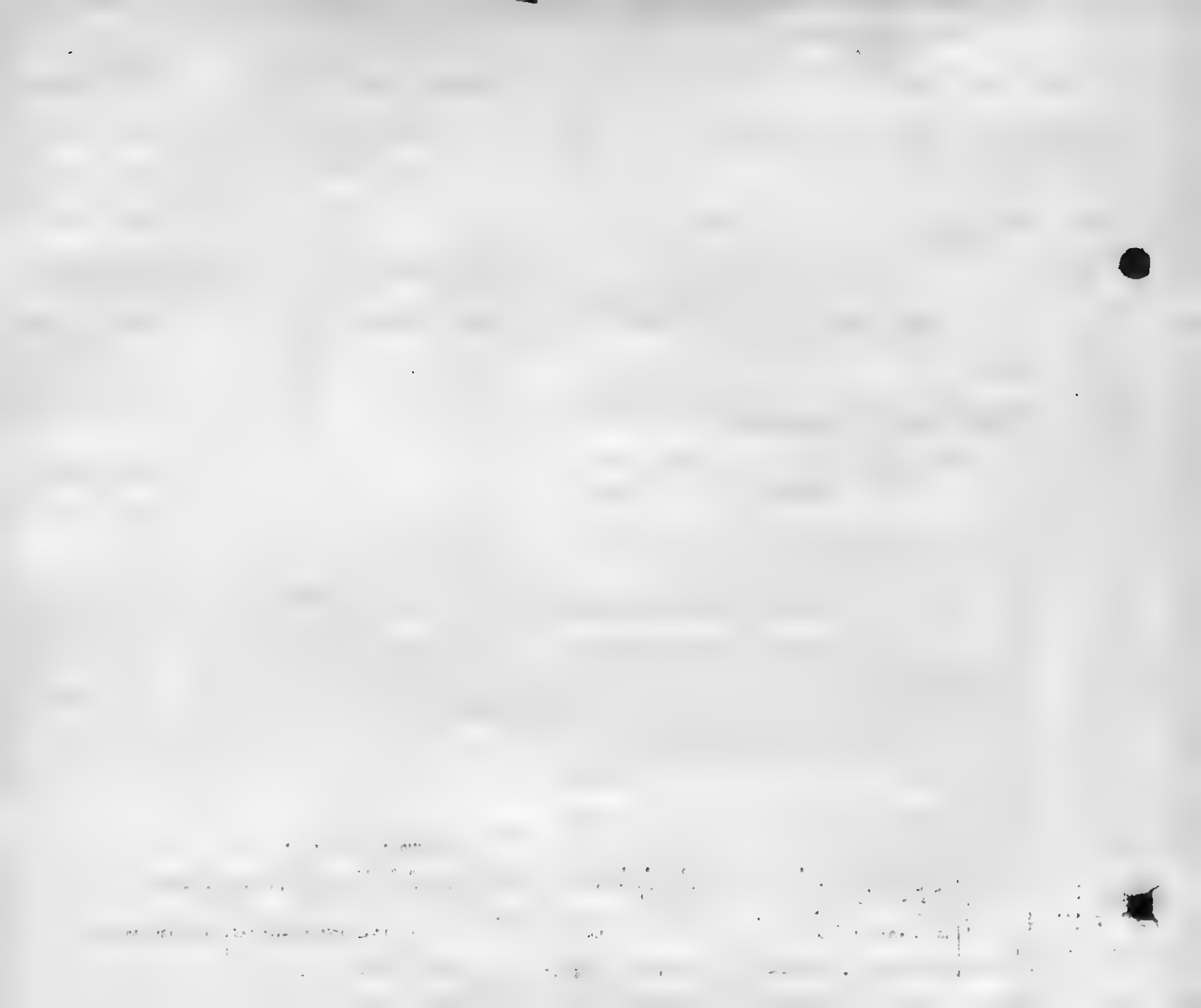
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH. Found drowned
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found drowned
20c. TIME OF INJURY Month, Day, Year 7/30/19 61
20d. INJURY OCCURRED White ☐ Not White ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Harbor
20f. (City or town) Anne Arundel (County) Md. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Peter W. Rieckert CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) Peter W. Rieckert, M.D. M.D. ASSISTANT MEDICAL EXAMINER ☐
Associate Pathologist Arthur L. Kneass
DATE SIGNED 7/31/61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 7-5-61
22c. NAME OF CEMETERY OR CREMATORY Golling Green
22d. LOCATION (City, town, or county) Phila. Pa. (State) Pa.

23. FUNERAL DIRECTOR William Reese, 47-Anna. Md. ADDRESS Phila. Pa.
24a. REC'D BY REGISTRAR AUG 7 '61
24b. REGISTRAR'S SIGNATURE Arthur L. Kneass



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7526
CERTIFICATE OF DEATH

07517

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>201 S. Southwood Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>MARX</u> Last <u>MARX</u>		4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>November 3, 1923</u>		9. AGE (In years last birthday) <u>37</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Maxwell Ochs</u>		14. MOTHER'S MAIDEN NAME <u>Ray Busky</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mr. Marcus S. Marx</u>		Address <u>Husband</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for a, b) and c) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Bleeding into cerebral metastases</u> 170X DUE TO (b) <u>metastatic adenocarcinoma of breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 hr.</u> <u>6 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (XXXXXX) attended the deceased from <u>7-20-61</u> 19 <u> </u> , to <u>July 20, 1961</u> , that (I) (was) last saw the deceased alive on <u>July 20, 1961</u> , and that death occurred at <u>3:49 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Shipley</u>		22b. DATE SIGNED <u>7/21/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 21, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Knoeth Israel</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JUL 24 '61</u>	
ADDRESS <u>Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07518

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>102 College Creek Terrace</u>		3. NAME OF DECEASED (Type or print) <u>Charles</u> First Middle Last <u>MATTHEWS</u>		4. DATE OF DEATH Month Day Year <u>July 17, 1961</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 2, 1905</u>		9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>56</u> yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE County & State, or foreign country <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Phebe Stevens</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-0687</u>		17. INFORMANT <u>Olivia Matthews, 102 College Creek Terrace</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiovascular disease</u> <u>0-6X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last } DUE TO (b) <u>aortic insufficiency</u> (c) <u>neuro-syphilis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1674</u>		20f. (City or town) (County) (State)							
21. I certify that (I) <u>deceased</u> attended the deceased from <u>June 21, 1961</u> to <u>July 16, 1961</u> that (I) <u>last</u> saw the deceased alive on <u>July 16, 1961</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Edith Rodler</u> M.D.		22b. DATE SIGNED <u>3:30 A.M.</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Edith Rodler</u>		22d. ADDRESS <u>45 Franklin St., Annapolis, Md.</u>		22e. REC'D BY REGISTRAR <u>Arthur L. Harris</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 7-22-61</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Broadneck</u>		23d. LOCATION (City, town or county) (State) <u>St. Mary's</u>		23e. REC'D BY REGISTRAR <u>July 26 '61</u>		23f. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>		23g. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07519

7528

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL CO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVIERA BEACH		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA - RIVIERA BEACH	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 164 DALE RD.		d. STREET ADDRESS 164 DALE RD	
3. NAME OF DECEASED (Type or print) JOHN WILLIAM McGUIRE		4. DATE OF DEATH Month JULY Day 17 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 25, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WORKER - SANITATION		10b. KIND OF BUSINESS OR INDUSTRY BALTO. CO.	9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR: Months 5 Days 9 IF UNDER 24 HRS.: Hours 5 Min. 9
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JOHN J. Mc GUIRE		14. MOTHER'S MAIDEN NAME ELIZABETH A. OHLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. 213-01-7825 HA	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH INIT. 5 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JAN 1961 to JULY 17, 1961 , that (I) (we) last saw the deceased alive on JULY 10, 1961 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE J. Brady Smith		22b. DATE SIGNED JULY 17, 1961	
22c. PHYSICIAN'S NAME (Type) J. BRADY SMITH		22d. ADDRESS RIVIERA BEACH, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/20/61	23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CATHOLIC Cem.	23d. LOCATION (City, town or county) (State) LONG GREEN MD.
24. FUNERAL DIRECTOR'S SIGNATURE John T. ...		25a. REC'D BY REGISTRAR ...	
25b. REGISTRAR'S SIGNATURE ...		25c. DATE JUL 21 '61	

7529

CERTIFICATE OF DEATH

Reg. Dist. No. 07520

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>	
c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>O.</u> Last <u>McKenzie</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/1867</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tobacco Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>George McKenzie</u>		Address <u>Lothian, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour <u>a. m.</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 5</u> , 19 <u>61</u> , to <u>July 17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>61</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Shadyside, Md.</u> DATE SIGNED <u>7/18/61</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/21/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of Sorrows Catholic Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Owensville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home-Upr Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 27 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Robert S. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7530

CERTIFICATE OF DEATH

Reg. Dist. No. 07521

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Knowlwood Nursing Home</u>		d. STREET ADDRESS <u>none</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA H MEADE</u>		4. DATE OF DEATH Month Day Year <u>July 14 19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1961</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Mr. Edward S. Sched- same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Death. Pulm Pneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u> cause (c) <u>Radio Uterus Hemorrhage</u> lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April 1961</u> to <u>July 14, 1961</u> , that I last saw the deceased alive on <u>June 30, 1961</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>609 Odenton Rd</u> DATE SIGNED <u>Febus F. Grunberg</u>			
ACTUAL SIGNATURE <u>Febus F. Grunberg</u>			
PHYSICIAN'S NAME (Type) <u>Febus F. Grunberg MD</u> <u>Odenton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 17, 61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Millersville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for his files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7531

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07522

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. COUNTY Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 26		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town, write STREET ADDRESS) Baltimore 26	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wieland Cove, Carvel Beach		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JERRY Jeery Lee Moon		4. DATE OF DEATH July 4th, 1961	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/48
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Pupil		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
13. FATHER'S NAME Gordon Leroy Moon		14. MOTHER'S MAIDEN NAME Violet Willetta Rollins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Parents		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia due to drowning 127.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Found drowned (Swimming)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Water	
20c. TIME OF INJURY Hour 11:30 a.m. Month, Day, Year 7/4 1961		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Water	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspec on <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from. Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/5/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 7-7-61	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or country) (State) Baltimore 26 MD	
23. FUNERAL DIRECTOR Mc Cully Funeral Hns.		24a. REC'D BY REGISTRAR JUL 7 '61	
24b. REGISTRAR'S SIGNATURE William S. Thomas		24c. ADDRESS 130 E. Fort Ave	



TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7532

07523

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>1 Mo. 10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2824 Baker St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Henry Moss</u> First Middle Last 4. DATE OF DEATH <u>July 29 1961</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>6/18/1895</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Allen Moss</u> 14. MOTHER'S MAIDEN NAME <u>Eva E. Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>Yes</u> (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>8995</u> 17. INFORMANT <u>Medical Record</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>304X</u> DUE TO <u>CVA</u> Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Brain Syndrome Associated with Cerebral Arterioscl.</u> (c) <u>Chronic Brain Syndrome Associated with Cerebral Arterioscl.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome Associated with Cerebral Arterioscl.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above. 22a. SIGNATURE <u>Charles Wood</u> 22c. PHYSICIAN'S NAME (Type) <u>Charles Wood</u> 22b. DATE SIGNED <u>Aug 2 1961</u> 22d. ADDRESS <u>Crownsville, Md.</u> 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8/2/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>E.D. Wilson</u> ADDRESS <u>1000 Brawthey Ave</u> 25a. REC'D BY REGISTRAR <u>AUG 3 '61</u> 25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7533

07524

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel Gen</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u> d. STREET ADDRESS <u>245 Glenwood Road.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank U. U</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/2/07</u> yrs. <u>54</u> 9. AGE (in years last birthday) <u>54</u> yrs. 10. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u> 11. CITIZEN OF WHAT COUNTRY? <u>USA</u>		4. DATE OF DEATH <u>7-15-1961</u> Month <u>7</u> Day <u>15</u> Year <u>1961</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin C Neat</u> 14. MOTHER'S MAIDEN NAME <u>Anna M. Jackson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Esther M. Neat 245 Glenwood Road Riviera Beach</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Acute Coronary Occlusion</u> DUE TO <u>& myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Chronic Cholecystitis & Cholelithiasis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 min</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>7/12/61</u> Hour <u>19</u> e.m. <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>7/12/61</u> <u>7/15/61</u> 20g. (County) <u>Prince George's</u> 20h. (State) <u>MD</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>7/12/61</u> to <u>7/15/61</u> , that (I) (we) last saw the deceased alive on <u>7/15/61</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Fred Hawkins Jr.</u> 22b. DATE SIGNED <u>7/15/61</u> 22c. PHYSICIAN'S NAME (Type) <u>J. Fred Hawkins Jr.</u> 22d. ADDRESS <u>98 Cathedral St. Annapolis</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7.19.61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> 23d. LOCATION (City, town or county) <u>A.A. Co Md.</u> (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>McCully</u> 25a. REC'D BY REGISTRAR <u>JUL 18 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7534

07525

1. PLACE OF DEATH a. COUNTY <u>An. Ar.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. A. I.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>33 Hicks Ave.</u>		d. STREET ADDRESS <u>33 Hicks Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Sidney Owens</u>		4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-12-1919</u>
9. AGE (In years last birthday) <u>41</u> yrs		IF UNDER 1 YEAR: Months <u>41</u> Days <u>16</u> Hours <u>16</u> Min. <u>16</u>	
10a. JSUA: OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Camilla Pinkney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-16-0417</u>	
17. INFORMANT <u>Margaret Gibson</u>		Address <u>46 parole st.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>162.1 Ironed by gas Cancer</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1961</u> to <u>7-16-61</u> , that (I) (we) last saw the deceased alive on <u>7-16-61</u> , and that death occurred at <u>7-16-61</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Paul T. Allen</u> M. D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED <u>7-17-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL T. ALLEN</u>		22d. ADDRESS <u>OL Cochrane St</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-19-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		25a. REC'D BY REGISTRAR <u>Anna</u> DATE <u>III 19 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>William Reese</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7535

CERTIFICATE OF DEATH

Reg. Dist. No. 07526

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Friendship MARYLAND A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendship				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendship			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Bessie Middle E. Last Paddy				4. DATE OF DEATH Month July Day 4 Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1879	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min.	IF UNDER 24 HRS. Hours 82 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Birckhead				14. MOTHER'S MAIDEN NAME Janie Fowler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Edna Paddy		Address Friendship, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Friendship	(County) A.A.	(State) Md.		
21. I certify that I attended the deceased from 5/12/61 , 19 61 , to 7/4/61 , 19 61 , that I last saw the deceased alive on 7/4/61 , 19 61 , and that death occurred at 2:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Emily H. Wilson				ADDRESS (Street, city or town, state) Lothian		DATE SIGNED 7-5-61	
PHYSICIAN'S NAME (Type) Emily H. Wilson				Lothian		A.A. Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 6, 1961	22c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery	22d. LOCATION (City, town, or county) (State) Friendship, A.A. Co., Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home				ADDRESS Quinn's Rd		24a. REC'D BY REGISTRAR DATE JUL 10 '61	24b. REGISTRAR'S SIGNATURE Arthur J. H.

CERTIFICATE OF DEATH

7536

07527

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY N ^o 2 mos. 10 da. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis d. STREET ADDRESS 1877 Highland Dr. Edgewater, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John f. First Middle Last 4. DATE OF DEATH PETRELLO July 20 1961		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Aug. 19, 1904 9. AGE (In years last birthday) 56 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resturant Owner 11. BIRTHPLACE (County & State, or foreign country) Washington, D. C. 12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Dominic Petrello 14. MOTHER'S MAIDEN NAME Elbina Scagnelli		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO Unknown 17. INFORMANT Mildred H Petrello Same As #2 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Carcinoma of lung & multiple metastasis to bone & skin DUE TO (b) 9 months or more DUE TO (c) one week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from May 10, 1961 to July 19, 1961 , that (I) (we) last saw the deceased alive on July 19, 1961 , and that death occurred at 7:50 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Willard F. Smith M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Willard Smith		22d. ADDRESS Shadyside, Md.	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 7/24/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	
23d. LOCATION (City, town or county) Bladensburg Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co 517 11th St. S.E. Wash D.C.		25a. REC'D BY REGISTRAR JUL 24 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

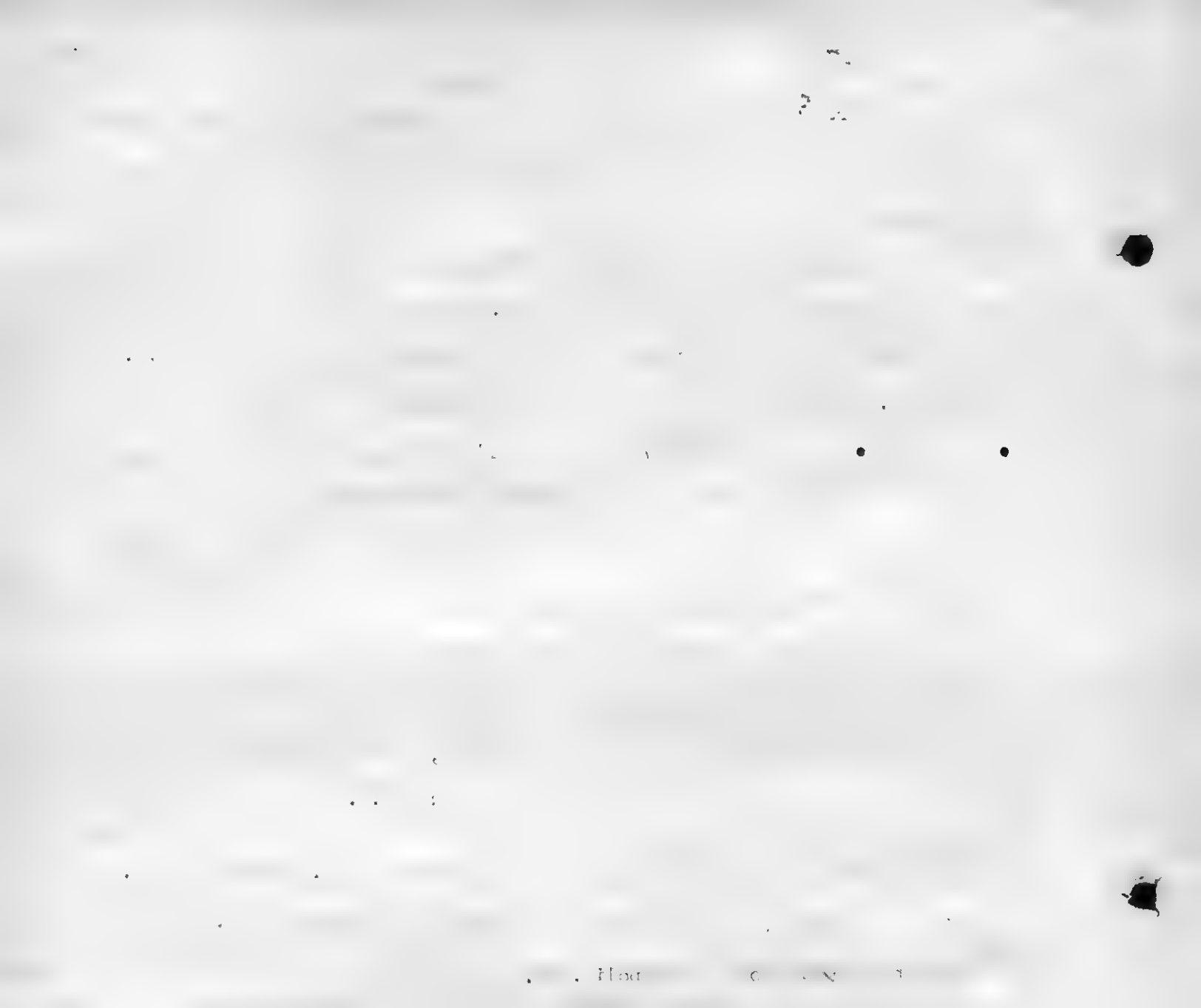
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7537

CERTIFICATE OF DEATH

07528

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>3 Silopanna Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lula</u> f. SEX <u>Female</u> g. COLOR OR RACE <u>White</u> h. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> i. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> j. KIND OF BUSINESS OR INDUSTRY <u>own home</u> k. BIRTHPLACE (County & State, or foreign country) <u>Alabama</u> l. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		4. DATE OF DEATH <u>July 22 19 61</u> m. AGE (In years last birthday) <u>67</u> yrs n. IF UNDER 1 YEAR Months Days Hours Min. o. IF UNDER 24 HRS. p. MOTHER'S MAIDEN NAME <u>Selma Raden</u>	
13. FATHER'S NAME <u>Bruce H. Kelly</u> q. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> r. SOCIAL SECURITY NO. <u>411 01 7625</u> s. INFORMANT <u>John Ellis Posey</u> t. INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>		16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage due to hypertension</u> DUE TO (b) <u>arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (DECEASED) attended the deceased from July 18, 19 61 to July 22, 19 61, that (I) (DECEASED) last saw the deceased alive on July 22, 19 61, and that death occurred at M. from the causes and on the date stated above. 22a. SIGNATURE <u>Frank M Shipley</u> 22c. PHYSICIAN'S NAME (Type) <u>FRANK M SHIPLEY</u> 22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u> 22e. DATE SIGNED <u>7-25-61</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>July 25, 61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Annapolis, Md.</u> 23e. REC'D BY REGISTRAR <u>Arthur L. Kraus</u> 23f. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> 23g. DATE <u>JUL 27 '61</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> 24a. ADDRESS <u>Annapolis, Md.</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7538
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07529

1 PLACE OF DEATH a. COUNTY <u>a. a.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>a. a.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>183 Gloucester St</u>		d. STREET ADDRESS <u>183 Gloucester St</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Anne Redmond</u>		4. DATE OF DEATH Month Day Year <u>7-10-1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 15-1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11 BIRTHPLACE (State or foreign country) <u>St Marys Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>William Basil</u>		14. MOTHER'S MAIDEN NAME <u>Althea Watson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>-</u>	
17 INFORMANT <u>Mrs George H. Weber</u> Address <u>(2)</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> 15 / X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> 19 <u>59</u> , to <u>7-10-1961</u> , that (I) (we) last saw the deceased alive on <u>7-10-1961</u> , and that death occurred at <u>-</u> M. from the causes and on the date stated above			
22a. SIGNATURE <u>James R. Martin</u> M. D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7-11-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		22d. ADDRESS <u>6 SHAW ST. ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-12-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Annies Cemt</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>		25a. REC'D BY REGISTRAR <u>JUL 12 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7539

07530

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY in lb. <u>4</u> years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (When deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1729 E. Federal St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Isabel</u> First Middle Last 4. DATE OF DEATH <u>July 29</u> 19 <u>61</u>		5. SEX <u>F.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 18, 1889</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (Country & State, or foreign country) <u>South Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>REED Samuel</u> 14. MOTHER'S MAIDEN NAME <u>ELSON Emma Mae</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Medical Record Department</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis and Septicemia</u> (b) <u>Decubitus Ulcers.</u> (c) <u>Senility.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration and Cachexia.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <u> </u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>		20c. TIME OF INJURY Month, Day, Year <u> </u> <u>19</u> Hour <u> </u> a.m. <u> </u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>July 17</u> 19 <u>61</u> to <u>July 29</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 29</u> 19 <u>61</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Isabel M. Mapp</u> 22c. PHYSICIAN'S NAME (Type) <u>Lone M. Mapp</u>		22b. DATE SIGNED <u>July 29</u> 19 <u>61</u> 22d. ADDRESS <u>Crownsville State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8-2-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u> 23d. LOCATION (City, town or county) <u>Anne Arundel Co., Md.</u> (State) <u> </u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>RANDOLPH COLLICK</u> ADDRESS <u>1412 E. PRESTON ST.</u> 25a. REC'D BY REGISTRAR <u>AUG 1 '61</u> 25b. REGISTRAR'S SIGNATURE <u>William S. Howard</u>	

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FOR STATE
HEALTH DEPT.

TO: DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, play a copy to the funeral director. Pages 1, 2, and 3 to be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. NO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9.60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7540 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07531											
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup c. LENGTH OF STAY IN TB 1 month d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Old Jessup Rd						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Wayne Edward Renfrow						4. DATE OF DEATH May July 22 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3 1961		9. AGE (in years last birthday) 2 yrs. 19		10. IF UNDER 1 YEAR 2 Months 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) New Albany, Indiana		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Iloff Neal Renfrow						14. MOTHER'S MAIDEN NAME Ruth Anne Coplin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. No		17. INFORMANT SP4 and Mrs. Iloff N. Renfrow (Parents)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation 724.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head was caught between mattress and crib rail							
20c. TIME OF INJURY 3:30 p.m. Month 7/22/61 Day 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
20f. (City or town, County, State) Jessup AA Md.											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Gustave Faubert						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Gustave Faubert MD						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Glen Burnie					
						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 25, 1961				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY Byrnesville Cem.			
22d. LOCATION (City, town, or country) Byrnesville Indiana											
23. FUNERAL DIRECTOR See with Donohue Funeral Home						24a. REC'D BY REGISTRAR Carlton S. Thomas					
						24b. REGISTRAR'S SIGNATURE					
						DATE JUL 31 '61					



FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, the medical director, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7541

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07532

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Latham Hills, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. ANNE ARUNDEL GENERAL</u>		d. STREET ADDRESS <u>7727 Lurison Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>KATHARINE LEE Rickenbacker</u>		4. DATE OF DEATH Month <u>7</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OF SKIN <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 16 - 1944</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>school</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur John Rickenbacker</u>		14. MOTHER'S MAIDEN NAME <u>Helen Lee Rose</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Helen Lee Rickenbacker</u>		Address <u>Hyattsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 979.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Interval BETWEEN ONSET AND DEATH</u> <u>Sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Swimming at Benedict Beach</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7.13</u> p.m. <u>1961</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <u>AACo MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/26/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or country) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 27 '61</u>	
ADDRESS <u>Hyattsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page MM3 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. C7533

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROSE HAVEN</u>		c. LENGTH OF STAY IN 1b <u>ROSE HAVEN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Abraham</u> Middle <u>Rose</u> Last <u>Rose</u>		4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9 1889</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant/Amusement</u>	
11c. PLACE OF BIRTH (State or foreign country) <u>Roumania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Solomon Rose</u>		14. MOTHER'S MAIDEN NAME <u>Sarah BENDICT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Joseph Rose Rose Haven Aa Co Md.</u>	
17. INFORMANT <u>Joseph Rose Rose Haven Aa Co Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac disease</u> 4:4 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (c), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7-6-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 9-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Sharon</u>		22d. LOCATION (City, town, or county) (State) <u>Springfield Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Knaub</u>	
ADDRESS <u>Annapolis Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaub</u>	
DATE <u>JUL 10 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7543
CERTIFICATE OF DEATH

07534

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 6020 Belle Grove Rd	
3. NAME OF DECEASED (Type or print) First William Middle Last Rose		4. DATE OF DEATH Month 7 Day 23 Year 1961	
5. SEX Male	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown Contractor		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown George Rose		14. MOTHER'S MAIDEN NAME Unknown Susie Ann ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown No		16. INFORMATION unknown Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular Disease (c) Chronic Brain Syndrome Assoc. with Arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Assoc. with Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 8 years	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year 19		20d. INJURY OCCURRED While el work <input type="checkbox"/> Not While el work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/19 to 7/23 19 61 that (I) (we) last saw the deceased alive on 7/23 19 61 , and that death occurred 8:40 A.M. from the causes and on the date stated above.			
22a. SIGNATURE George M. K. Phillips		22b. ADDRESS CROWNVILLE Md.	
22c. PHYSICIAN'S NAME (Type) George M. K. Phillips		22d. ADDRESS CROWNVILLE Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 26, 1961	
23c. LOCATION Mt. Auburn Cem. Balto. Md.		23d. LOCATION Mt. Auburn Cem. Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Kate R. Williams		25. REC'D BY REGISTRAR Jul 25 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
7546									
CERTIFICATE OF DEATH									
07535									
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis					b. COUNTY Anne Arundel				
c. LENGTH OF STAY IN 1b 3 Days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mayo				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital, Annapolis, Md.					d. STREET ADDRESS P.O. Box 34				
3. NAME OF DECEASED (Type or print) Laura Hallett					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX Female					6. DATE OF BIRTH 8 June 1870				
6. COLOR OR RACE Cauc					7. AGE (in years last birthday) 5 yrs.				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF DEATH 7 10 1961				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) Alabama					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME George ALLETT					14. MOTHER'S MAIDEN NAME Lottie JY ON				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. None				
17. INFORMANT Mary Hallett, P.O. Box 34, Mayo, Md.					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of bladder and</u>									
DUE TO (c) <u>fecal-urinary fistula</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from... 7 July..., 1961 to... 10 July..., 1961 that (I) (we) last saw the deceased alive on... 10 July 1961 and that death occurred 9:45 PM from the causes and on the date stated above.									
22a. SIGNATURE Stephen B. Hittalide									
22b. DATE SIGNED 10 July 1961									
22c. PHYSICIAN'S NAME (Type) U.S. Naval Hospital, Annapolis, Md.									
22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)									
23b. DATE THEREOF									
23c. NAME OF CEMETERY OR CREMATORY									
23d. LOCATION (City, town or county) (State)									
24. FUNERAL DIRECTOR'S SIGNATURE									
25a. REC'D BY REGISTRAR									
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and properly filled in by the attending physician and co-attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7545

C7536

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN TB 3 hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission)
a. STATE Maryland
b. COUNTY Anne Arundel
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 19 College Creek Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) SELLMAN
First Middle Last
4. DATE OF DEATH July 6, 1961
Month Day Year
5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH July 6, 1961
yrs. Months Days Hours Min.
9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS.
last birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Arthur Alvin Sellman 14. MOTHER'S MAIDEN NAME Rosie Elizabeth Naylor
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Summation
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (deceased) attended the deceased from July 6, 1961 to July 6, 1961 that (I) was last saw the deceased alive on July 6, 1961, and that death occurred at 12:30 P.M. M, from the causes and on the date stated above.

22a. SIGNATURE Dr. A. T. Allen M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED July 6, 1961
22c. PHYSICIAN'S NAME (Type) Dr. A. T. Allen 22d. ADDRESS 62 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 8 July 1961 23c. NAME OF CEMETERY OR CREMATORY Hopewell Chapel Cm. 23d. LOCATION (City, town or county) (State) Edgewater, Md.

24. FUNERAL DIRECTOR'S SIGNATURE Wm. Leese II ADDRESS 1084 Oak St. Annapolis 25a. REC'D BY REGISTRAR JUL 11 '61 25b. REGISTRAR'S SIGNATURE William L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please return page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
7546 Items 13 & 14 from Gc9c 8/15/61 iwk
CERTIFICATE OF DEATH

Reg. Dist. No. 07537

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel, MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pennsylvania</i> b. COUNTY <i>Lloydell</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shadyside</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>None 75X-3</i>	
3. NAME OF DECEASED (Type or print) <i>Rudolph Daniel Silberhorn</i>		4. DATE OF DEATH <i>July 12 1961</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 7, 1890</i>
9. AGE (In years last birthday) <i>71 yrs.</i>		10. IF UNDER 1 YEAR: Months <i>11</i> Days <i>11</i> Hours <i>11</i> Min. <i>11</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Catholic Priest</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Rev. Charles White, Creoson, Pa.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i> <i>years</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>on July 12, 1961</i> , 19____, that I last saw the deceased alive on <i>July 12, 61</i> , 19____, and that death occurred at <i>6:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Willard F. Smith</i> M.D.		ADDRESS (Street, city or town, state) <i>Shadyside, Md.</i> DATE SIGNED <i>7/12/61</i>	
PHYSICIAN'S NAME (Type) <i>WILLARD F. SMITH, MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/17/61</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph's</i>		22d. LOCATION (City, town, or county) (State) <i>Beaverdale, Cambria, Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. L. Donnelly</i> ADDRESS <i>Beaverdale Pa</i>		24a. REC'D BY REGISTRAR <i>7-14-61</i> 24b. REGISTRAR'S SIGNATURE <i>Lauren Diamond</i>	

JUL 31 '61

Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7547

07538

1. PLACE OF DEATH a. COUNTY <u>Crownsville A.A. County</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>since 4/15/59</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp. it, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>2509 Madison Ave. Balto Md</u> d. STREET ADDRESS <u>2509 Madison Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Daisy Smith</u>		4. DATE OF DEATH Month <u>7</u> - Day <u>15</u> - Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. PLACE (City, County & State, or for foreign country) <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rubin Pake</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Pake</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
a. I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Heart failure</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Renal failure -</u>			
} (c) <u>CBS & atherosclerosis</u>			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS and CNS Les.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-17-1959</u> to <u>7-15-1961</u> that (I) (we) last saw the deceased alive on <u>7-15-1961</u> and that death occurred at <u>6pm</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Hildegard Heard Reissman</u>		22b. DATE SIGNED <u>7/17/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissman, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/20/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Belmont Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Balto Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Nutter</u>		25a. REGD BY REGISTRAR <u>JUL 24 61</u>	
ADDRESS <u>3035 W. North Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kram</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7548
CERTIFICATE OF DEATH

07539

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u> d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Baby</u> First Middle Last		4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>7-13-61</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years, last birthday) IF UNDER 1 YEAR F UNDER 24 HRS. yrs. Months Days Hours M n. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William PARKER</u>		14. MOTHER'S MAIDEN NAME <u>Ida Lucille Sollers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>William PARKER Hospital files</u>	
17. INFORMANT <u>Lothian, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>13 July 1961</u> to <u>15 July 1961</u> , that (I) (we) last saw the deceased alive on <u>14 July 1961</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above	
22a. SIGNATURE <u>James I. Hudson, Jr.</u>		22b. DATE SIGNED <u>21 July 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>James I. Hudson, Jr., M.D.</u>		22d. ADDRESS <u>South River Medical Center, Edgewater, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>July 15, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ADAMS CHAPEL</u>		23d. LOCATION (City, town or county) (State) <u>LOTHIAN, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>T A Hardisty + Son</u>		25a. REC'D BY REGISTRAR <u>Galeville, MD</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. French</u>		25c. DATE <u>JUL 19 1961</u>	

1000192 XV 2





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7550

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07541

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>				c. LENGTH OF STAY IN 1b <u>one day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1841 A St., SE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>WALTER</u> Last <u>Stover</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9, 1906</u>	
9. AGE (In years last birthday) <u>54</u> yrs		IF UNDER 1 YEAR Months <u>54</u> Days <u>54</u> Hours <u>54</u> Min. <u>54</u>		IF UNDER 24 HRS Months <u>54</u> Days <u>54</u> Hours <u>54</u> Min. <u>54</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>		11. BIRTHPLACE (State or foreign country) <u>HARRISONBURG VA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>RALEIGH STOVER</u>				14. MOTHER'S MAIDEN NAME <u>NELLIE RALLS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give nature, dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
17. INFORMANT <u>RUTH May Stover</u>				Address <u>1841-A St SE WASH DC</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Unusual exertion (Lifting boat anchor)</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>WILLARD F. SMITH, MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or MOVIAL (Specify)		22b. DATE THEREOF <u>7/10/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SMITHLAND R.R. 660 Co., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>				ADDRESS <u>817-11951 SE WASH DC</u>		24a. REC'D BY REGISTRAR <u>DATE 11 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



7551

CERTIFICATE OF DEATH

Reg. Dist. No. 07542

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Weems Creek) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Weems Creek, Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 631 Ridgley Ave.				d. STREET ADDRESS 631 Ridgley Ave			
3. NAME OF DECEASED (Type or print) SUSAN AUSTIN BILLINGS TEEPLE				4. DATE OF DEATH Month JULY Day 16 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1866	9. AGE (In years last birthday) 94 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Brooklyn, N.Y.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John Punderson Ballings				14. MOTHER'S MAIDEN NAME Ann Eliza Kuykandall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs Ernest E. Brooks, Daughter same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Generalized Arteriosclerosis (c) Senility						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Brooklyn, N.Y.		(County) (State)	
21. I certify that I attended the deceased from 5-19 , 19 52 , to 7-16 , 19 61 , that I last saw the deceased alive on 7-16 , 19 61 , and that death occurred at 5:17 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 45 Franklin St, Annapolis Md DATE SIGNED 7-17-61							
ACTUAL SIGNATURE Edith Rodler M.D.		PHYSICIAN'S NAME (Type) Dr. Edith Rodler 45 Franklin Street, Annapolis, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 20, 1961	22c. NAME OF CEMETERY OR CREMATORY Evergreens Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn, N.Y.			
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md				24a. REC'D BY REGISTRAR DATE JUL 21 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
7552 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
07543									
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Epping Forrest					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Epping Forrest				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) River View Trail					d. STREET ADDRESS River View Trail				
3. NAME OF DECEASED (Type or print) First Middle Last EDITH MARGARET THIEL					4. DATE OF DEATH Month Day Year July 24 1961				
5. SEX Female					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH JAN. 8th 1920				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE					10b. KIND OF BUSINESS OR INDUSTRY HOME				
11. BIRTHPLACE (State or foreign country) NEW YORK CITY					12. CITIZEN OF WHAT COUNTRY? U.S.A				
13. FATHER'S NAME NILS ERIKSON					14. MOTHER'S MAIDEN NAME EDITH ZETTERBERG				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) -					16. SOCIAL SECURITY NO. -				
17. INFORMANT ROBERT I. THIEL					Address (2)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease with Mitral and Aortic Valvular Stenosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UNKNOWN (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) -									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -					20f. (City or town) (County) (State) -				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/25/61									
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty, M.D.					Address (Street, city, town, or county) -				
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation					22b. DATE THEREOF 7-26-1961				
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cmt					22d. LOCATION (City, town, or country) (State) Bladensburg Md				
23. FUNERAL DIRECTOR John M. Taylor Sons Annapolis Md					24a. REC'D BY REGISTRAR DATE JUL 26 '61				
					24b. REGISTRAR'S SIGNATURE Charles S. Petty				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7553

07544

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1 year 1 month
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Valley Lee
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital
e. STREET ADDRESS 15x
f. RESIDENCE ON A FARM? YES ☐ NO ☐

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE Maryland b. COUNTY St. Mary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Valley Lee
d. STREET ADDRESS 15x
e. RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) TURNER T. THOMPSON
First Last
4. DATE OF DEATH July 9, 1961
Month Day Year

5. SEX Male 6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 11-24-44
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years, if UNDER 1 YEAR, last birthday) 16 yrs. Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student
10b. KIND OF BUSINESS OR INDUSTRY Valley Lee
11. BIRTH PLACE (County & State, or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Turner T. Thompson, Sr.
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? no 16. SOCIAL SECURITY NO. no 17. INFORMANT Address no

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Circulatory Insufficiency - Shock
493x DUE TO
Conditions, if any, which gave rise to immediate cause (b) Pneumonia
(c) DUE TO
cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER). 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 9-28 1959 to 7-9 1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St. George's
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-28 1959 to 7-9 1961, that (I) (we) last saw the deceased alive on 7-9 1961, and that death occurred at 7:30 AM, from the causes and on the date stated above.

22a. SIGNATURE Addison W. Pope M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ 22b. DATE SIGNED 7-9-61
22c. PHYSICIAN'S NAME (Type) ADDISON W. POPE MD. 22d. ADDRESS Crownsville State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7/12/61 23c. NAME OF CEMETERY OR CREMATORY St. George's 23d. LOCATION (City, town or county) (State) Valley Lee Md.

24. FUNERAL DIRECTOR'S SIGNATURE McClarke Mattingley, Leonardtown, Md. 25a. REC'D BY REGISTRAR Arthur S. Kenna 25b. REGISTRAR'S SIGNATURE Arthur S. Kenna
DATE JUL 11 '61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7554

07545

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b Shadyside			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Shadyside			
3. NAME OF DECEASED (Type or print) First Alfred Middle D. Last Tubb				4. DATE OF DEATH Month July Day 14 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-27-88	
9. AGE (In years and months) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer				10b. KIND OF BUSINESS OR INDUSTRY Printing			
13. FATHER'S NAME Dwight Tubb				14. MOTHER'S MAIDEN NAME Viola Gayle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 577 10 3521			
17. INFORMANT Mary Louise Tubb				Address Shadyside MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia (terminal) 162. } DUE TO Bronchogenic carcinoma of left upper lobe of lung Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO metastases to left ventricle of heart (c) over one year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 days							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 2, 1960 to July 14, 1961 , that (I) was last saw the deceased alive on July 14, 1961 , and that death occurred 10:50 from the causes and on the date stated above.							
22a. SIGNATURE Willard J. Smith				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/14/61	
22c. PHYSICIAN'S NAME (Type) Dr. Willard Smith				22d. ADDRESS Shadyside, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 7-15-61		23c. NAME OF CEMETERY OR CREMATORY Home Birmingham Alabama		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty				25a. REC'D BY REGISTRAR DATE JUL 19 1961		25b. REGISTRAR'S SIGNATURE Arthur L. Hinkle	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

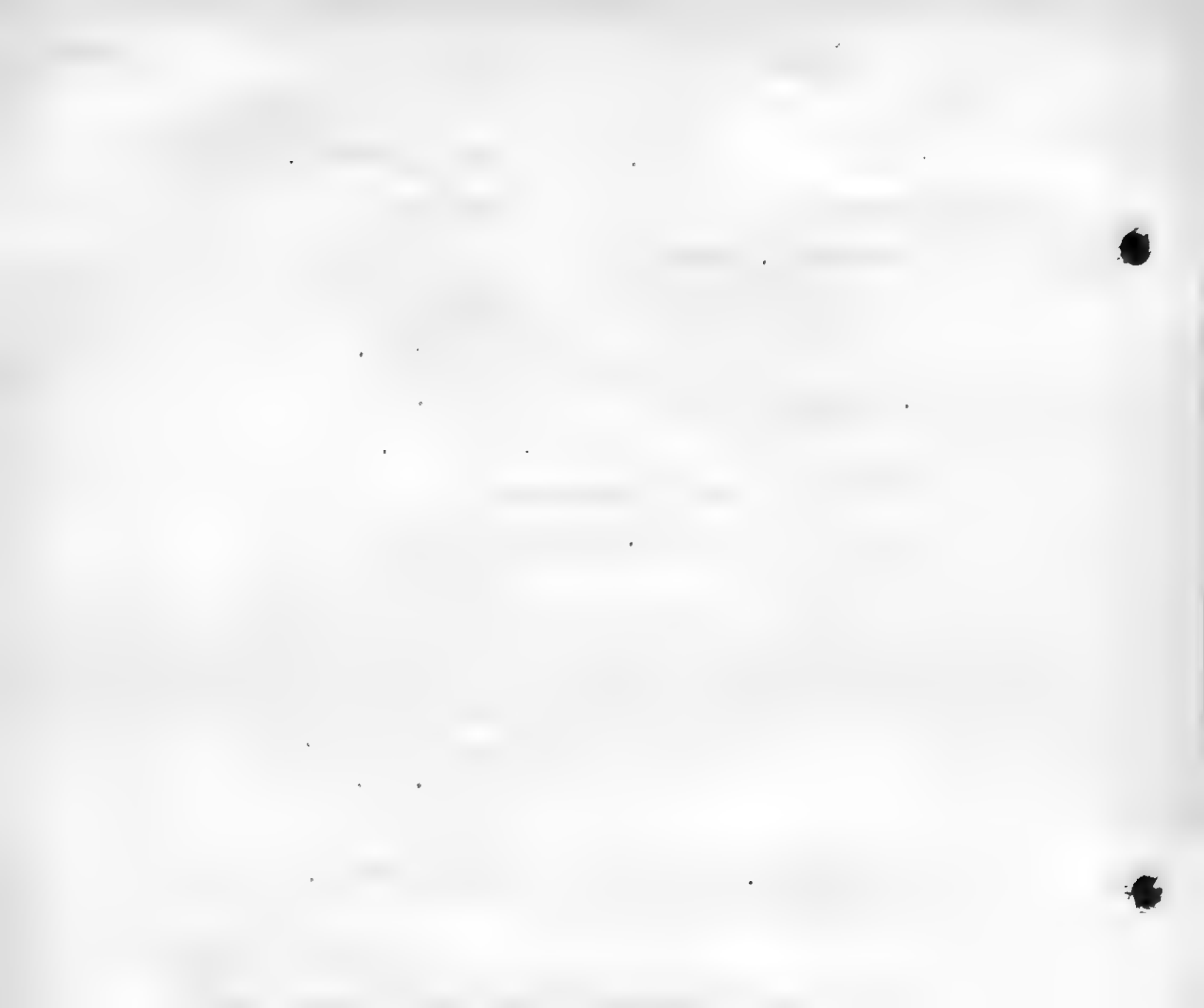
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7555

CERTIFICATE OF DEATH

07546

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville c. LENGTH OF STAY IN 1b 14 1/4 hrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Norwood Nursing Home		2. USUAL RESIDENCE (Where deceased lived at STATE a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eirleih Heights, P.O. Severna Park d. STREET ADDRESS Box 322 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret L. Wagner First Middle Last		4. DATE OF DEATH July 15th 1961 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/85
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John H. Robinson		14. MOTHER'S MAIDEN NAME Mary A. Rush	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Margaret L. Miller (daughter)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Insufficiency 421.0 DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Unknown ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/28/61 19____ to 7/15/61 19____, that (I) (we) last saw the deceased alive on 6/15/61 19____, and that death occurred on 8.30 P.M. the causes and on the date stated above			
22a. SIGNATURE Gustave H. Faubert, M.D.		22b. DATE 7/15/61	
22c. PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.		22d. ADDRESS Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/18/1961	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		25a. REC'D BY REGISTRAR 8728 Liberty Rd.	
25b. REGISTRAR'S SIGNATURE Ran. Hallston, Md.		25c. DATE JUL 20 '61	



CERTIFICATE OF DEATH

Reg. Dist. No.

07547

7555

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Acton Place</u>				d. STREET ADDRESS <u>14 Acton Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>WALTERS</u> Last				4. DATE OF DEATH Month <u>JULY</u> Day <u>2</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 11, 1903</u>		9. AGE (In years last birthday) <u>57</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prop.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Amusement Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Morris Walters</u>			
14. MOTHER'S MAIDEN NAME <u>Fannie Novabetsky</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>no</u>			
16. SOCIAL SECURITY NO. <u>215 07 6279</u>				17. INFORMANT <u>Mrs Dena Walters- Wife- Same ad # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Carcinomatosis</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Lung</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>4 mrs</u> <u>7</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1144 P</u>	
20f. (City or town) <u>Annapolis</u>				20g. (County) <u>Anne Arundel</u>		20h. (State) <u>Maryland</u>	
21. I certify that I attended the deceased from <u>Feb. 15, 1961</u> to <u>July 2, 1961</u> , that I last saw the deceased alive on <u>July 2, 1961</u> , and that death occurred at <u>1144 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>31 Southgate Ave., Annapolis, Maryland</u> DATE SIGNED <u>July 3, 1961</u>							
ACTUAL SIGNATURE <u>Maruice F. Klawans</u> M.D.				DATE SIGNED <u>July 3, 1961</u>			
PHYSICIAN'S NAME (Type) <u>Maruice F. Klawans MD</u>				ADDRESS <u>31 Southgate Ave., Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 4, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kneseth Israel</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawns</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF BIRTH

STATE OF NEW YORK

County of _____

I, _____, Clerk of the County of _____, do hereby certify that on the _____ day of _____, 19____, at _____, in the County of _____, State of New York, was born to _____ and _____, a child of the name of _____, sex _____, color _____, and age _____.

Witness my hand and the seal of the County of _____, at _____, this _____ day of _____, 19____.

Clerk of the County of _____

Mayor of the City of _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7557

07548

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis, Maryland c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4502 Frederick Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond E. Yantz		4. DATE OF DEATH Month July Day 2 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1899
9. AGE (in years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 14 Days 1	
11. IF UNDER 24 HRS. Hours 1 Min. 37		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George S. Yantz		14. MOTHER'S MAIDEN NAME Jeannette Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Mrs. Janet R. Yantz		Address 4502 Frederick Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 14 1/2 1 3/4			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7-2-61 to 7-2-61 , that (I) (we) last saw the deceased alive on 7-2-61 , and that death occurred at 6:55 PM from the causes and on the date stated above.			
22a. SIGNATURE James R. Martin M.D. 22c. PHYSICIAN'S NAME (Type) JAMES R. MARTIN		22b. DATE SIGNED 7-2-61 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS ANNAPOLIS, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF July 5, 1961	23c. NAME OF CEMETERY OR CREMATORY Hillcrest	23d. LOCATION (City, town or county) (State) Cumberland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker & Sons ADDRESS Baltimore, Maryland		25a. REC'D BY REGISTRAR JUL 3 '61 25b. REGISTRAR'S SIGNATURE William S. Henshaw	

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